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	12/26/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 30678 Based on interview and record review the facility failed to notify a family member of a resident fall for one (R1) of three residents reviewed for falls in the sample of eight. Findings include: The facility's Change in a Resident's condition or Status policy and procedure, dated 05/17, documents Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. Unless otherwise instructed by the resident, the nurse will notify the resident's representative when: The resident is involved in any accident or incident, including injuries of unknown source and There is a significant change in the residents' physical, mental or psychosocial status. The Fall Event for R1, dated 9/6/24 at 7:15 am, documents R1 self-reported she lost her balance, fell in her room, and hit her head during the night. This Event documents R1 with a knot on mid (middle) occipital region of her head. This Event does not document anyone was notified of R1's fall. The Progress Note for R1, dated 9/6/24 at 10:51 am, documents V13 (R1's) PCP (Primary Care Physician) was notified of R1's self-reported fall during the night three hours and 36 minutes after R1 reported the fall. There are no Progress Notes documenting R1's family or representative was notified until 9/7/24 at 1:40 pm. This Progress Note documents V14 RN (Registered Nurse) spoke with V15 (R1's) Family Member, 29 hours after R1 reported she had a fall. (V14 RN) documented she spoke to (V15 R1's Family Member) regarding R1's condition and (V15) states he was not aware of the fall and requested R1 be sent to the hospital for evaluation of Occipital Hematoma, headache, and vision loss of left eye. The Progress Note for R1, dated 9/7/24 at 2:07 pm, documents (V15/ R1's Family Member) called back requesting he be given the documented times of when he was notified of (R1) falling. (V14 RN) endorsed this task to the manager on call. Manager notifying (V1 Administrator). (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

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 12/26/2024
NAME OF PROVIDER OR SUPPLIER Lincoln Village Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2202 North Kickapoo Street Lincoln, IL 62656	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/24/24 at 12:03 pm, V1 Administrator confirmed V15 (R1's) Family Member was not notified of R1's self-reported fall on 9/6/24 because at that time R1 was alert, oriented, cognitively intact, and was her own Power of Attorney. V1 Administrator stated if a resident is cognitively intact, they are their own POA and Family Members are not generally notified unless the resident is unable to make decisions for themselves or unable to communicate. On 12/26/24 at 10:45 am, V16 Regional Director confirmed the facility policy is that family members or emergency contacts are notified of resident falls, injuries or change in condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30678 Based on interview and record review the facility failed to implement complete neurological assessments, provide continuous monitoring, and provide timely hospital transfer for one (R1) of three residents reviewed for quality of care in the sample of eight. Findings include: The Residents' Rights for People in Long-Term Care Facilities, dated 11/18, documents Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source. Your facility must provide services to keep your physical and mental health, at their highest practical levels. The facility's Change in a Resident's condition or Status policy and procedure, dated 05/17, documents the Nurse will notify the resident's attending physician when: the resident has a significant change in status, resident's treatment needs altered significantly, or is necessary or in the best interest of the resident. The nurse will record in the resident's medical record any changes in the resident's medical condition or status; and If a significant change in resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted. The Face Sheet for R1 includes the following diagnoses: History of cerebral infarction (stroke); Disseminated demyelination (damage to fatty tissue that protects and insulates nerve cells in the brain and spinal cord); Chronic respiratory failure with hypoxia; Congestive heart failure; Atherosclerotic heart disease of coronary artery, and Aortocoronary bypass graft. The Quarterly Progress Note for R1, dated 10/15/24, documents R1 is cognitively intact and has adequate hearing and vision with the help of glasses at times, is able to walk with use of walker and wheelchair at times. The Fall Event for R1, documents R1 had an unwitnessed fall on 9/6/24 at 7:15 am in R1's room. The Description of R1's fall is documented as lost balance, hit head, no loc (loss of consciousness). The initial assessment was completed and documents knot on mid occipital (side of the head that processes visual information) region with no other findings and documents None required for Medical Care Provided After The Fall. The interventions and immediate measures taken at the time of the fall are documented as analgesics and increased supervision or monitoring. The Neurological Flow Sheet documents Neuro Check Time Schedule as: every 15 minutes for one hour; every 30 minutes for two hours; every hour for four hours; every four hours for 24 hours; and every shift for 48 hours. This Neurological Flow Sheet was initiated on 9/6/24 at 7:20 am and is documented up to 9/6/24 at 2:50 pm. There are no neurological checks completed after the 9/6/24 at 2:50 pm. The Progress Note for R1 dated 9/6/24 at 7:15 am, documents (R1) self-reported that (R1) got up in the middle of the night, it was dark and (R1) lost her balance falling to the floor. (R1) has a knot on mid occipital region. No other injuries noted. (R1) alert and oriented to her norm (normal), neuro (neurological checks) and vitals initiated and unit nurse to notify MD (Medical Doctor). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note for R1, dated 9/7/24 at 5:30 am, documents (R1) reported falling to the floor to the morning nurse. Neurological flow sheet is incomplete with no times and only 5 sets of vitals. (R1) has a knot on the mid occipital region. No other injuries noted. This same note documents R1 stated she is in pain and Norco (opioid pain medication) given at 8:30 pm. The Progress Note for R1, dated 9/7/24 at 1:34 pm, documents (R1) c/o (complained of) complete vision loss in her left eye. (R1) recently had an un-witnessed fall during the night on 9/6/24. (R1) has a hematoma to her occipital lobe. (R1) complained of headache as 10 out of 10. The Progress Note for R1, dated 9/7/24 at 1:49 pm documents V14 RN notified the on-call manager and called 911 for transport. The Progress Note for R1, dated 9/7/24 at 6:21 pm, by V14 RN documents Resident being admitted for atherosclerosis of the neck. (R1) will be transferred to (another local hospital). The facility's Admission/Discharge Report, documents R1 was sent out to the local hospital on 9/7/24 and was readmitted to the facility on [DATE]. The local hospital History and Physical for R1, dated 9/7/24, documents Impression/Plan as: 1. CVA (Cerebrovascular Accident) occipital - (R1) has left-sided blurry vision however she reports she is already improving. CT (computed tomography) head showed hypotensive and right occipital lobe. CTA (computed tomography angiography) with multiple findings as mentioned in HPI (history of present illness). Stroke 1 (emergency stroke level protocol) already on board. We will obtain MRI (Magnetic Resonance Imaging) head. We will obtain TTE (transthoracic echocardiogram). Continue aspirin, Plavix as advised by Stroke 1. Currently does not have any motor deficits. Vascular surgery consultation in am (morning). 2. ACA (aneurysm of the anterior communicating artery) seen on CT Angio (angiogram). Neurosurgery follow up as an outpatient. 3. UTI (urinary tract infection) UA (urinary analysis) from (local hospital) did show WBC (white blood cell) 11-20 with bacteria 4+ and we will put her on ceftriaxone (antibiotic) 1 g (gram) daily. Other comorbidities: Previous history of stroke and CABG (coronary artery bypass graft surgery). The MRI of the brain for R1, dated 9/8/24 documents Impression: 1. Tiny focus of abnormal diffusion signal within the left occipital cortex most consistent with tiny acute/subacute infarct. 2. Additional extensive chronic small-vessel ischemic and lacunar changes. Sequela of prior infarct right parietooccipital lobe. 3. Parenchymal atrophy. The ventricles are more prominent compared to the sulci which could relate to atrophy but does raise the possibility of normal pressure hydrocephalus. The Hospitalist Progress Note for R1, documents Impression and Plan as: 1. Cerebrovascular Accident Occipital. Symptoms have significantly improved. MRI (Magnetic Resonance Imaging) shows very small area now. 2. Anterior communicating artery aneurysm small. 3. Suspected UTI (Urinary Tract Infection. The Stroke Chart Note for R1, dated 9/8/24, documents (R1's) workup is complete. TTE shows EF (ejection fraction) 550% (percent) with no obvious cardiac source of stroke. MRI shows a small, acute infarct in the left occipital lobe, as well as chronic right occipital stroke. This new infarct does not explain left eye vision loss. (R1's) left eye symptoms may thus be due to central/branch retinal artery occlusion. The small left occipital stroke on MRI is very likely due to her extensive atherosclerotic disease of the cerebral vasculature. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Discharge Plan for R1, dated 9/14/24 documents I was in the hospital because: Occipital stroke. On 12/24/24 at 1:12 pm, V3 LPN/ADON (Assistant Director of Nursing) stated she was helping the Nurse with paperwork to send R1 to the hospital because R1 to V2 Former DON (Director of Nursing) that she fell going to the bathroom and hurt her tailbone and requested to go to the hospital. V3 LPN stated at the time R1 didn't have a POA, was able to make her own decisions so we didn't call her family. V3 LPN/ADON stated If it wasn't documented then (V15 R1's Family Member) wasn't called. (R1) did not have a POA (Power of Attorney) on file. If someone is alert and oriented, I believe the cut off is 13 out of 15 on BIMS we would not notify the family. V3 LPN/ADON stated family is called Only if the resident is not able to make their own decisions or communicate. On 12/26/24 at 10:35 am, V1 Administrator confirmed R1 had a fall on 9/6/24, neurological checks were not fully completed for R1, and R1 returned to the facility on [DATE] with a diagnosis of Left Occipital Stroke. On 12/26/24 at 10:40 am, V16 Regional Director confirmed Neurological Checks and vital signs should have been fully completed up to the time of R1's discharge to the local hospital and had they been done may have alerted staff to send R1 to the hospital sooner.

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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 - 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. 30678 Based on observation, interview, and record review the facility failed to provide safety during resident cares, keep supplies in reach, and do a thorough fall investigation for one (R6) of three residents reviewed for fall safety during cares. Findings include: The facility's undated Managing Falls and Fall Risk policy and procedures documents Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. The facility's undated Resident Rights Statement documents Residents will be cared for in a manner and in an environment that promote maintenance or enhancement of each resident's quality of life, dignity, and aspect in full recognition of his or her individuality. The facility's undated CNA (Certified Nursing Assistant) job description, documents The primary purpose of this position is to: Assist nursing personnel in providing nonprofessional nursing care and simple technical nursing services under the direction and supervision of an RN (Registered Nurse) or LPN (Licensed Practical Nurse). This policy also documents the CNA will: Ensure that all transfers and lifts are performed with concern for the safety of the resident according to the policies of the facility. Ensure that all CNA care plan approaches and interventions are being utilized as planned; Make sure that necessary supplies are available .; Assists with and/or performs procedures as outlined, with proper instruction and supervision; and Ensure the resident environment is as free from accidents and hazards as is possible. The CNA Orientation documents Training and instruction has been given to the employee regarding the following topics: Perineal Care; Bed Bath; Positioning; Re-directing resident from unwanted or unsafe behavior(s); and Maintaining a safe and hazard-free environment. The Face Sheet for R6 includes the following diagnoses for R6 as: Contracture of right knee, Contracture of left knee, Vitamin D Deficiency, GAD (Generalized Anxiety Disorder), Frontotemporal Neurocognitive Disorder, Dementia, History of Traumatic Brain Injury, and unspecified Psychosis. The Quarterly Social Service Note for R6, dated 11/27/24 at 3:35 pm, documents R6 is a long-term resident of facility, has clear speech, adequate hearing, and vision with glasses, able to make her wants and needs known, and able to make simple daily decisions. R6 has a BIMS (Brief Interview for Mental Status) score of 14 out of 15, indicating R6 is cognitively intact. The most recent Fall Risk assessment for R6, dated 9/19/24 scored R6 as 13 indicating she is a High Risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current Care Plan for R6, documents (R6) has the potential for fall and is at risk for falls r/t (related to) unaware of safety needs, psychoactive drug use, TBI (traumatic brain injury), abnormal posture and has a history of falls. The interventions for R6 include encourage to change position slowly; know R6's habits to anticipate needs; and have commonly used items in reach. R6 requires total staff participation for bathing, incontinence care, and to re-position and turn in bed. This same Care Plan documents to monitor R6 for incontinence, provide peri care and may apply barrier cream. The Progress Notes for R6 documents the following: 12/18/24 at 8:42 pm (late entry note) Resident fell while being cleaned, hit her head, 911 and family called; 12/18/24 at 8:40 pm, MD (Medical Doctor) notified of fall, order to send resident to ER (emergency room) for evaluation and treatment; and 12/19/24 12:41 am, Resident seen at (local hospital) - has left femur fracture and awaiting ortho (orthopedic) consult. The Progress Note for R6, dated 12/19/24 at 6:09 am, documents Writer summoned to room by V12 CNA (Certified Nursing Assistant), V12 CNA stated that Resident (R6) fell out of the bed while being changed. V12 CNA stated that (R6) said she hit her head and no bleeding. Writer printed paperwork, called 911 and family, writer entered the room, (R1) observed in a sitting position underneath the bedside table and writer assessed the best of ability w/o (without) moving. (R6) mark noted to center of forehead and took vitals. Awaited paramedics to arrive. The Fall Event report for R6, dated 12/19/24, documents on 12/18/24 R6 was being assisted with cares by (V12) CNA and during cares R6 fell from her bed onto the floor and R6 reported hitting her head. The Initial Report sent to the State Agency, dated 12/18/24 at 8:42 pm, documents an investigation was initiated for R6 after a fall from bed. This report documents Resident was reaching for object out of bedside table and rolled out of bed. CNA was present in the room, witnessed the fall. Resident hit her head but did not lose consciousness. R6 was sent to the local hospital emergency room for evaluation. The Hospital Medical Record for R6, dated 12/18/24, documents R6 was admitted to the local hospital with a left proximal femur fracture. The Hospital Medical Record discharge record documents R6 required a surgical cephalomedullary nailing (a nail is surgically placed into the femur bone) as treatment for R6's femur fracture. The Facility's Final Report to the State Agency documents R6 with a BIMS (Brief Interview for Mental Status) of 14 out of 15 indicating R6 is cognitively intact with diagnoses of frontotemporal neurological cognitive disorder and has bilateral lower extremity contractures. While CNA was providing care, (R6) reached for the bedside drawer and had episode of leg spasms; slipped from the bed to the floor. Resident immobilized and sent to emergency room . After the initial assessment R6 was diagnosed with a left proximal femur fracture. On 12/26/24 at 10:10 am, R6 was sitting in a wheelchair in the dining room with her bilateral knees contracted upward. R6 stated one of the CNAs pushed her onto her side, was cleaning her up and R6 fell on the floor. R6 stated she doesn't remember who the CNA was but that the CNA was not holding onto (R6). R6 stated she was sent to the hospital and the x-ray showed (R6) had a broken femur. R6 stated It was so painful. It is better but still causes me pain. R6 stated no one has talked to her about what happened other than this writer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/24/24 at 11:40 am, V6 LPN (Licensed Practical Nurse) stated she was the nurse on call the night R6 fell . V8 Agency RN (Registered Nurse) reported that R6 was reaching for something in her drawer and rolled right out of bed. V6 LPN stated it was only reported that R6 had hit her head and is why R6 was sent to the hospital. V12 CNA was in the room with R6 when R6 fell . On 12/26/24 at 10:35 am, V1 Administrator stated she did the investigation for R6's fall. V12 CNA was the CNA providing care when R6 fell . V1 Administrator stated she spoke with V12 CNA who was providing care and R6 reached over to get something out of her nightstand and fell on the floor. V1 Administrator stated she did not interview anyone else, including R6. On 12/26/24 at 10:40 am, V16 Regional Director educated V1 Administrator that (V1) should always interview the resident when there is a fall, even if (V1) has to go to the hospital to get the interview. V16 Regional Director confirmed V12 CNA should not have turned away from R6. On 12/26/24 at 1:26 pm, V12 CNA stated she was providing incontinence care to R6 when R6 fell out of bed. V12 CNA stated R6 was lying in bed on her right side, facing the door and V12 was on the opposite side of the bed to R6's back. (V12) stated she cleaned R6 and turned to find R6's barrier cream and when she turned back R6 was falling out of the bed. V12 CNA confirmed (V12) didn't know if R6 was reaching for something or trying to grab onto something due to falling. It happened so fast. V12 CNA stated she did not have her hands on R6 and stated (V12) shouldn't have turned away from R6

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 33975 Based on observation, interview, and record review the Facility failed to employee a full time Director of Nursing. This failure has the potential to affect all 75 Residents residing in the Facility. Findings include: The Facility Daily Census Report, dated 12/24/24, documents 75 Residents residing in the Facility. The Facility Assessment Tool, dated 7/10/24, does not document a Director of Nursing. The Assessment also documents: that a Director of Nursing is needed to provide support and care for Residents; reviews the regulation for the Facility Assessment requirements; the Facility identifies the type of staff members and Nursing Services (Director of Nursing); and the Infection Control Committee is composed of the following personnel (Director of Nursing). The Facility Director of Nursing Job Summary, update 7/14/20, documents that the Director of Nursing will develop, monitor, and adapt as necessary the Facility's clinical program; keep the Facility prepared for State and Federal Inspections; and participate in the survey process with the Administrator and maintain current Federal and State Regulations. On 12/24/24 and 12/26/24, during the hours of 8:00 am and 3:00 pm, the Facility did not have a Director of Nursing on staff. V2's (Former Director of Nursing/DON) written statement, dated 12/10/24, documents, I am resigning effective immediately from my employment opportunity. On 12/24/24, V3 (Assistant Director of Nursing/ADON) stated, We have been without a 'DON' for a few weeks now. I am a Licensed Practical Nurse/LPN. We do not have a DON right now, so I am helping out. On 12/24/24, V1 (Administrator in Training) stated, (V2/Former Director of Nursing) just walked off of the job a few weeks ago and we have not had a Director of Nursing since. (V3/ADON) is filling in. I am hoping to get someone interviewed, I have one in mind that lives out of town, but I have not interviewed them yet.