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	07/02/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy to ensure resident to resident physical abuse did not occur for one resident (R5) reviewed for abuse in a sample of four. Findings include: Facility's Abuse Policy, reviewed 5/19/25, documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Abuse means any physical or mental injury or sexual assault inflected upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Facility's Initial and Final Reports to (State Department of Public Health) for R4 and R5, dated 5/19/25, document: There was an altercation between R4 and R5. R4 ambulates with his walker and attends activity sessions in the dining room. While R4 was seated with the walker by his side, R5, who propels himself with a wheelchair, entered the dining room and moved R4's walker to provide more space. As soon as R5 moved R4's walker, R4 hit R5's face in attempt to stop him from moving it. 1. R5's diagnoses include: Mantle cell lymphoma, malignant neoplasm of prostate, generalized anxiety disorder, personal history of other venous thrombosis and embolism. R5's Minimum Data Set/MDS dated [DATE] documents R4 has a BIMS (Brief Interview of Mental Status) of 6 on a scale of 00 - 15 indicating severe impairment. (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.) R5's progress note, dated 5/18/25 documents: (R5) involved in altercation in dining room with another resident (R4) and was struck in the Left cheek. On 6/27/25 at 1:35pm, R5 stated he did not remember any altercation that he had with R4. 2. R4's diagnoses include: Mild intellectual disabilities, malignant neoplasm of right testis, schizoaffective disorder, major depressive disorder, chronic kidney disease. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Minimum Data Set/MDS dated [DATE] documents R4 has a BIMS score of 15 on a scale of 00 - 15. R4's current Care Plan documents: Category: Mood State: (R4) exhibiting change in usual behavior as evidenced by increased restlessness, fidgety, lack of initiative/involvement, and being irritated. Category: Behavioral Symptoms: (R4) shows signs of physical aggression when agitated. Threw his television/TV remote at nurse when she was attempting to give him medications. Category: Behavioral Symptoms: (R4) displays verbal behavioral symptoms directed toward others as evidenced by pacing, cursing, and verbally threatening others when he is agitated.: R4's Progress Note, dated 5/18/25 documents: An altercation occurred in the main dining room between R4 and R5. R4 observed yelling at R5 for allegedly grabbing (R4's) walker. Before staff could intervene, resident swung and struck R5 in the cheek. R4's 5/19/25 statement regarding the altercation documents: After (V5) grabbed (V4's) walker, I tapped him on his nose very lightly and the nurse got upset. On 6/27/25 at 1:25pm, R4 stated that he does not recall the 5/18/25 altercation with R5. On 7/1/25 at 11:35am, V1 Administrator stated that the altercation between R4 and R5 occurred on the weekend during resident activities; stated that the staff who witnessed the altercation (V16 Agency Registered Nurse/RN) assessed both R4 and R5 and found no injuries. V1 stated that (V1) attempted to contact V16 several times for interview but was unable to reach her/V16. On 7/1/25 at 11:35am, V1 stated, They (R4 and R5) were separated immediately after the incident, we made sure that during activities, make sure the tables had more space between them. R4 does not like his things touched; he hit R5 in the face in the nose area. R4 said his walker was moved and this upset him.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record review, the facility failed to thoroughly investigate an allegation of resident to resident abuse for one resident (R8) reviewed for abuse in a sample of four. Findings include: Facility's Abuse Policy, reviewed 5/19/25, documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This will be done by implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. Reports will be documented, and a record kept of the documentation. VII. 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 1. R7's Progress Note, dated 6/8/25 at 7:38pm, documents: Resident had incident with roommate. Roommate placed in another room. 2. R8's Progress Note, dated 6/8/25 at 7:34pm documents: Resident had incident with roommate and resident was moved to (another room). Resident okay with move. Skin assessment done and no injuries noted. There was no other documentation in the Electronic Health Records/EHRs for either R7 or R8 regarding the 6/8/25 incident. (Documentation and staff interviews indicated R7 and R8 were roommates at the time of the 6/8/25 incident.) On 6/27/25 at 1:40pm, R7 stated that she did not remember details about the incident involving her former roommate (R8). R7 Stated that regarding throwing her meal tray, that she probably threw the tray on the floor; I was pissed, same da*n food all the time. On 7/1/25 at 11:35am, V1 Administrator stated that the 6/8/25 incident occurred during dinner time in R7 and R8's room; stated that she interviewed both R7 and R8 about the incident but did not document her interviews in the EHRs; and stated that she did not interview staff who were aware of the incident. V1 stated that (V12/LPN) was the night shift nurse for (R7 and R8) but (V1) did not interview V12/LPN. At this same time, V1 stated there was no other documentation or investigation documentation regarding the incident. V1 stated, I was told that the tray that (R7) threw did not make contact with R8; I was under the impression that I had enough information and did not investigate further.

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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. Based on observation, interview, and record review, the facility failed to document and implement a treatment order for one resident (R3) and failed to follow its policy for labeling and dating wound dressings after treatments for two (R1, R6) residents reviewed for wound care/treatments in a sample of four. Findings include: The facility's Medication and Treatment Orders policy, Revised 7/2016, documents: 3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. The facility's Medication Orders Policy, Revised 11/2014, documents: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. A current list of orders must be maintained in the clinical record of each resident. 6. Treatment Orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment. The facility's Wound Care Policy, Revised 10/2010, documents: 13. Dress Wound. [NAME] tape with initials, time, and date and apply to dressing. The facility's Skin and Wound Management Policy, Reviewed 1/2025, documents: 10. Document in the clinical record when treatments are performed. 1. R3's Progress Note Dated 5/12/25 documents: Resident (R3) evaluated during wound care rounds. Rash to chest and abdomen assessed. R3's Specialty Physician Order (Wound Evaluation and Management Summary Dated 5/30/25) documents: Diagnosis: Scabies. Treatment: Permethrin (Elimite) 5% to whole body for 12 hours. Repeat in seven/7 days. Review of R3's Electronic Health Record/EHR for May 2025 and June 2025 indicated no treatment order or staff signage for Elimite for R3. On 7/1/25 at 1:05pm, V2 Director of Nursing/DON verified that R3's Treatment Order for Elimite which was prescribed by V17 Wound Physician was not documented in R3's Physician Orders or in R3's Treatment Administration Record/TAR in the EHR. V2 stated, Apparently he (R3) was not treated with the Elimite. 2. On 6/27/25 at 11:00, R1 noted to have dressings to bilateral heels; dressings are clean, dry and neatly intact. Dressings were not dated. R1's Specialty Physician Wound Evaluation and Management Summary order, dated 6/30/25 documents: Skin prep, alginate calcium once daily and as needed. On 6/27/25 at 1:55pm, R6 was noted to have dressings to pressure wound of right upper groin; dressings clean, dry and intact; undated. R6's Specialty Physician Wound Evaluation and Management Summary Order dated 5/12/25 documents: Alginate calcium with silver; apply once daily and as needed for 30 days; collagen sheet apply once daily and as needed for 30 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/25 at 11:35am, V4 Licensed Practical Nurse/LPN/Wound Nurse stated that residents' wound dressings were not labeled and dated; stated that once the staff signage is complete in the Treatment Administration Record/TAR, that is the documentation needed for the wounds. On 7/2/25 at 10:15am, V4 LPN/Wound Nurse stated that she has been employed at the facility almost a year. V4 stated, I was told by facility staff that this (labeling and dating wound dressings after treatment) was not done at this facility; policy was to document in the TAR only.