| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>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.

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|---|---|
| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to issue a written notice of room moves for three of four residents (R13, R14, and R27) reviewed for room moves in a sample of 30. Findings include: The facility's Room Changes Policy, dated 1/2025, documents Policy: To make room changes when requested by the resident or as may become necessary to meet the resident's medical and nursing care needs. Policy Specifications: 2. Unless medically necessary for the safety and well-being of the resident(s), a resident will be provided with advance notice of the room change, at least two days before relocation, however, the resident has the right to relocate prior to the expiration of the two-day notice. Such notice will include the reason(s) why the move is recommended. 3. Prior to the room change, the resident, his or her roommate (if any), and the resident's representative will be provided with information concerning the decision to make the room change. 1. R13's current Census Sheet documents R13 had room moves on 2/8/25, 2/13/25, 2/19/25, 3/7/25, and 5/1/25. R13's MDS (Minimum Data Set) Assessment, dated 7/11/25, documents R13 is cognitively intact. R13's Electronic Medical Record does not include a notice of room change issued to R13 for R13's room moves on 2/8/25, 2/13/25, 2/19/25, 3/7/25, and 5/1/25. On 7/16/25 at 11:04 AM R13 stated, I am never made aware of reasons for room moves and they (the facility) make us change rooms a lot. I do not like it.2. R14's current Census Sheet documents R14 moved rooms from the [NAME] Hall to the [NAME] Hall on 5/8/25. R14's MDS Assessment, dated 5/13/25, documents R14 is cognitively intact. R14's Electronic Medical Record does not include a notice of room change issued to R14 or R14's representative. On 7/17/25 at 11:56 AM R14 stated he was never made aware of the reason why they moved him to another room and never received a written notice of room change. 3. R27's current Census Sheet documents R27 moved rooms on 2/1/25, 2/28/25, and 5/19/25. R27's MDS Assessment, dated 7/3/25, documents R27 is cognitively intact. R27's Electronic Medical Record does not include a notice of room change issued to R27 or R27's representative. On 7/17/25 at 11:07 AM V2/Director of Nursing stated R27 is alert and able to answer questions appropriately by shaking his head yes or no.On 7/17/25 at 11:11 AM R27 was asked by this surveyor if he has moved rooms in the facility a few times in the past 6 months. R27 shook is head yes. R27 was asked if they ever let him know the reasons why he was moved rooms and R27 shook his head no. On 7/17/25 at 11:20 AM V6/R27's Family Member stated they called her on one room move (2/28/25) and told her they moved R27 to a different room, but never told her a reason why. V6 stated the facility never let her know about the room moves on 2/1/25 or 5/19/25.On 7/17/25 at 11:24 AM V1/Administrator in Training verified R13, R14, and R27 did have multiple room moves and they (the facility) did not issue any written notice of room moves to R13, R14, R27 or their representatives. V1 stated, I was unaware we were supposed to issue a written notice to the resident or representative of the room moves and the reason we (the facility) are moving the resident(s) to a different room. |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's responsible party after a significant weight loss was identified for one of four residents (R1) reviewed for notifications of change in a sample of 30. Findings include:The facility's Weight Assessment and Intervention Policy, dated 1/2025, documents The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month- Five percent weight loss is significant; greater than 5% is severe. b. 3 months- 7.5 percent weight loss is significant; greater than 7.5% is severe. c. 6 months- 10 percent weight loss is significant; greater than 10 percent is severe.The facility's Notification of Consumer Change in Condition Policy, dated 1/2025, documents Policy: It is the policy of this facility to promptly notify the consumer, their legal representative(s) and attending physicians of changes in the consumer's health condition. Policy Specifications: To establish guidelines for assuring consumers, their legal representative and attending physicians are informed of changes in the consumer's condition. As per the Guidelines for Reporting to Physicians as per INTERACT Change in Condition Guidelines. Responsibility: Director of Nursing and Licensed Nurses. Standards: 3. Clinical change in condition is determined by consumer visualization, medical record review, clinical assessment findings and care plan review. Review of high-risk clinical issue such as skin breakdown, falls, weight loss, dehydration and others are conducted on a daily basis. 12. Consumer representative(s) notifications and attempts will be made promptly and documented in the nurses' notes. In the event the licensed nurse is unable to contact the consumer's representative, after a reasonable time period, the director of Nursing will be notified.The facility's Notification of Change Guidelines, dated 1/2025, documents Purpose: It is the practice of this facility that changes in a resident condition or treatment are immediately shared with the resident and/or resident representative, according to their authority, and are reported to and consulted with the attending physician. The resident and/or the resident representative will be educated about treatment options and supported to make an informed decision. Responsible Party: Clinical. Physician Notification and Consultation- Notification is provide to residents and/or the resident representative(S) to promote the right to make informed decisions regarding choices for care and treatment while keeping them informed about their current health status.1. R1's Face Sheet, dated 7/16/25, documents R1 is a [AGE] year-old male that admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Cerebral Palsy, Epilepsy, Unspecified Intellectual Disabilities, Hypothyroidism, Bradycardia, and Dysphagia, and Gastrostomy Status Placed 4/30/25.R1's MDS (Minimum Data Set) Assessment, dated 7/1/25, documents R1 had a significant weight loss of five or more percent in one month and/or ten percent or more in six months and is not on a physician-prescribed weight loss regimen.The facility's Weight Variance Report, dated 1/1/25 through 7/9/25, documents R1 weighed 126.2 pounds on 6/3/25 and 109.60 pounds on 7/1/25 indicating R1 had a severe weight loss of 13.2 percent weight loss in one month.R1's Electronic Medical Record does not include notification to V22/R1's Guardian of R1's severe weight loss of 13.2 percent identified on 7/1/25.On 7/15/25 at 9:35 AM V22/R1's Guardian stated she was never notified of R1's significant weight loss identified on 7/1/25 or any weight loss prior to that date. V22 stated, I would have liked to have known about (R1's) severe weight loss. I am very involved in (R1's) care and want him to be able to return to where (R1) lived prior to admitting to (this facility).On 7/15/25 at 10:12 AM V18/Regional Director stated it is the responsibility of the Director of Nursing to notify the family after a significant weight loss is identified. V18 stated, I cannot find any documentation of anyone notifying V22/R1's guardian of R1's significant weight loss identified on 7/1/25. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to protect a resident from staff-to-resident verbal abuse for one of three residents (R13) reviewed for staff-to-resident abuse in the sample of 30. Findings include:The facility's Abuse Prevention Policy, undated, documents The 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 facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of the individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again.R13's MDS (Minimum Data Set) assessment dated [DATE] documents R13 is cognitively intact.On 7/16/25 at 2:45 PM R13 stated, One night about a month ago a CNA (Certified Nursing Assistant/unknown name) picked up a trash can and wanted to throw it at me and cussed me out. I reported this to (V3/Prior Director of Nursing). (V3) told me she fired the CNA because of abusing me. I felt threatened.On 7/17/25 at 11:00 AM V1 (Administrator-In-Training) stated, I was on maternity leave around a month ago, so (V18/Regional Director) was covering for me. A CNA should not cuss or threaten to throw a trashcan at (R13). (R13) would know if this happened and would know if the CNA still works here. I have not been able to figure out who the CNA was, as (R13) said she no longer works here. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain consent prior to administering psychotropic medications for one of three residents (R1) reviewed for psychotropic medications in a sample of 30.Findings include:The facility's Psychotropic Medication Policy, dated 2/2014, documents Policy: To establish the process for monitoring the use of and the Reduction of doses of psychotropic medications without compromising the resident's health and safety, ability to function appropriately, or the safety of others. Policy Specifications: Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident guardian, or other authorized representative.R1's Face Sheet, dated 7/16/25, documents R1 admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Unspecified Intellectual Disabilities and Epilepsy.R1's current Physician Order Sheet documents R1 receives Risperidone (psychotropic medication) 0.5 mg (milligram) tablet twice a day and Clobazam (psychotropic medication) 5mg twice a day.On 7/15/25 at 9:35 AM V22/R1's Guardian stated she never verbally gave consent or signed an informed consent for R1's psychotropic medications.On 7/15/25 at 2:24 PM V1/Administrator in Training stated, We (the facility) could not locate an informed psychotropic consent for (R1). We should have obtained one prior to administering (R1's) psychotropic medication.On 7/17/25 at 10:07 AM V19/Regional Nurse Consultant verified an informed psychotropic consent could not be produced for the use of R1's Psychotropic medication. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to implement their Abuse Policy to immediately report an allegation of resident abuse to the State Agency and Administrator for one of seven residents (R13) reviewed for Abuse in the sample of 30.Findings include:The facility's Abuse Prevention Policy, undated, documents The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. V. Internal Reporting Requirements and Identification of Allegation: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Any allegation of abuse or any incident that results in a serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported withing 24 hours. External Reporting- 1. Initial Reporting of Allegations: When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator or designee, shall notify Department of Public Health's regional office immediately by telephone of fax. Public health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. 2. Five-day Final Investigation Report: Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.R13's MDS (Minimum Data Set) assessment dated [DATE] documents R13 is cognitively intact.On 7/16/25 at 2:45 PM R13 was lying in bed. R13 stated, One night about a month ago a CNA (Certified Nursing Assistant/unknown name) picked up a trash can and wanted to throw it at me and cussed me out. I reported this to (V3/Prior Director of Nursing). (V3) told me she fired the CNA because of abusing me. I felt threatened.R13's Electronic Health Record and the facility's Abuse Investigations do not include evidence of the administrator or the State Agency being notified of R13 alleging a CNA cursed at R13 and threatened to pick up a trash can and throw the trash can at R13.On 7/17/25 at 11:00 AM V1 (Administrator-In-Training) stated, I was on maternity leave around a month ago, so (V18/Regional Director) was covering for me.On 7/17/24 at 11:25 AM V18 (Regional Director) verified V3 did not report R13's allegation that a CNA cursed at R13 and threatened to throw a trash can at R13. V18 stated V3 should have reported the allegation to V18 immediately. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to immediately investigate an allegation of resident abuse for one of seven residents (R13) reviewed for Abuse in the sample of 30.Findings include:The facility's Abuse Prevention Policy, undated, documents The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. VII. Internal Investigation- 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 8. Final Investigation Report: The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident.R13's MDS (Minimum Data Set) assessment dated [DATE] documents R13 is cognitively intact.On 7/16/25 at 2:45 PM R13 was lying in bed. R13 stated, One night about a month ago a CNA (Certified Nursing Assistant/unknown name) picked up a trash can and wanted to throw it at me and cussed me out. I reported this to (V3/Prior Director of Nursing). (V3) told me she fired the CNA because of abusing me. I felt threatened.R13's Electronic Health Record and the facility's Abuse Investigations do not include evidence of an investigation being conducted regarding R13 alleging a CNA cursed at R13 and threatened to pick up a trash can and throw the trash can at R13.On 7/17/25 at 11:00 AM V1 (Administrator-In-Training) stated, I was on maternity leave around a month ago, so (V18/Regional Director) was covering for me.On 7/17/24 at 11:25 AM V18 (Regional Director) verified V3 did not report R13's allegation that a CNA cursed at R13 and threatened to throw a trash can at R13, therefore an investigation has never been done. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on interview and record review the facility failed to provide residents with a bed hold and written notice of transfer when transferring to the hospital for three of three residents (R3, R13, and R14) reviewed for hospital transfers in a sample of 30. Findings include: The facility's Transfer and Discharge Policy, un-dated, documents Policy: To assure resident transfers and discharges will be conducted in accordance with residents' rights, physician orders, and in such a manner as to maintain continuity of care for the resident. Policy Specifications: 2. When the facility transfers or discharges a resident under any circumstances, the resident/authorized legal representative must be notified verbally and in writing at least 30 days prior to the intended discharge unless the resident waives the notification period or in an emergency. (including situations where the safety of other residents may be compromised). The facility must also: b. Include a written notice to the resident/authorized legal representative the following. i. reason for transfer/discharge; ii. Effective date of transfer, iii. Location to which the resident will be transferred/discharged ; iv. A statement that the resident has the write to appeal the action to the State; v. the name, address, and telephone number of the State long term care ombudsman; and vi. Any other appropriate advocacy or protective services agency as required by the state. The facility's Bed Hold Policy Notification, undated, documents This Bed Hold Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility. 1. R3's current Census Sheet, documents R3 was sent to the hospital on 1/13/25 and 7/5/25. R3's medical record did not contain documentation of a written notice of the facility's bed hold policy or notice of discharge was given to R3 or R3's representative for 1/13/25 and 7/5/25. 2. R13's current Census Sheet, documents R13 was sent to the hospital on 6/26/25. R13's medical record did not contain documentation of a written notice of the facility's bed hold policy or notice of discharge was given to R13 or R13's representative for 6/26/25. 3. R14's current Census Sheet, documents R14 was sent to the hospital on 2/9/25. R14's medical record did not contain documentation of a written notice of the facility's bed hold policy or notice of discharge was given to R14 or R14's representative for 2/9/25. On 7/16/25 at 10:30 AM V1/Administrator in Training verified R3 or R3's representative was not given a bed hold or notice of transfer on 1/13/25 and 7/5/25 when transferred to the hospital, R13 or R13's representative was not given a bed hold or notice of transfer on 6/26/26 when transferred to the hospital, and R14 or R14's representative was not given a bed hold or notice of transfer on 2/9/25 when transferred to the hospital. V1 stated When any resident goes out to the hospital, they should receive a bed hold and a written notice of transfer. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident received a consultation with a lymphedema specialist and a nephrologist, as ordered by the physician, for one of four residents (R26) reviewed for physician orders in the sample of 30. Findings include:The facility's Physician Orders Policy, dated 1/23/25, documents Procedures: 6. Nursing staff will follow physician orders. In an event where a resident refuses medication or treatment, or medication is not available, Physician or Nurse Practitioner will be notified.The facility's Transportation Policy, dated 6/21/2021, documents Policy: It is the policy of this facility to assist residents in obtaining transportation when necessary for services outside the facility. Standards: 3. Nursing or Social Service personnel or designee shall assist residents in obtaining transportation when it is necessary to obtain medical, dental, diagnostic, or other services outside the facility. Staff shall be familiar with requirements for prior approval from the State Department of Public Aid, as appropriate. 10. If the facility is unable to provide in-house transportation, an outside transport will be sough within a reasonable travel distance.R26's Face Sheet documents R26 was admitted on [DATE] with the following, but not limited to, diagnosis: Lymphedema, Type Two Diabetes Mellitus, Stage Two Chronic Kidney Disease, and Hyponatremia.R26's Physician Order Sheet, dated 4/8/25, documents Start Date 4/8/25: Follow up with nephrologist in one to two weeks for hyponatremia. Start Date 4/8/25: Follow up with outpatient lymphedema clinic.R26's Progress Note dated 5/21/25 at 9:54 AM documents, Reviewed for significant weight gain of 50 pounds past month per fluid status/lymphedema. Good appetite per regular diet with 1500 cc (cubic centimeters) fluid restriction. Nursing to review with physician as need for diuretic. Per staff, not following 1500 cc fluid restriction.R26's Physician's Order dated 5-22-25 documents, Lymphedema clinic consult for evaluation and treatment.R26's Electronic Medical Record does not include evidence of R26 receiving a physician ordered consult with an outpatient lymphedema clinic or a physician ordered follow up with a nephrologist.On 7/17/25 at 9:40 AM R27 was lying in her bed in her room. R27's bilateral lower extremities were swollen, dry, and had multiple dry scabs. R27 stated, I admitted to this facility to get treatment for my lymphedema so I can return home. I have never received my appointment to see a lymphedema specialist or to see my nephrologist and would like to receive them so I can work towards going home.On 7/15/25 at 1:15PM V25/Receptionist stated, I had called a Lymphedema Specialty Clinic to get an appointment for (R27) at some point and the Lymphedema Specialty Clinic stated they needed a referral from a Lymphedema Specialist to be able to see (R27). I let V3/Prior Director of Nursing know what the Lymphedema Specialty Clinic said. I did not hear anymore after that and did not schedule any other appointment for (R27) to go to a Lymphedema Specialty Clinic. I am unaware of (R27) needing a follow up appointment for nephrology.On 7/17/25 at 11:20AM V7/Transportation/Scheduling stated, I am responsible for scheduling appointments and taking residents to their appointments. (V3/Prior Director of Nursing) never let me know that (R27) needed a follow up appointment with a Nephrologist after (R27's) admission to (our facility). That appointment never got scheduled. (V3) did ask me to set up an appointment for (R27) to see a Lymphedema Specialist. I reached out to a few Lymphedema clinics. I got an appointment set up at a clinic, but then they called back and said there is no lymphedema doctor at that clinic and that I would need a referral sent to them by a Lymphedema Specialist for them to see (R27). I let (V3) know this. (V3) told me to search for a Lymphedema Specialist in the area. We (the facility) cannot transport residents over a 50-mile radius due to the transportation van liability. I could not find a Lymphedema Specialist within that radius, so I again let (V3) know. (V3) never let me know anything after that, so (V3) never seen a Lymphedema Specialist.On 7/17/25 at 11:25 AM V1/Administrator in Training verified R27 had never received an appointment to see a Lymphedema Specialist or to see a Nephrologist as physician ordered. V1 stated We (the facility) are getting (R27) set up today to see a Lymphedema Specialist and a Neurologist. (V3/Prior Director of Nursing) did not let me know there was an issue getting (R27) in for her appointments. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>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) |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>Lincoln, IL 62656 |

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|---|---|
| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to update a pressure ulcer care plan and implement pressure relieving interventions for one of three residents (R1) reviewed for pressure ulcers in the sample of 30.Findings include:The facility's Prevention of Pressure Wounds Policy, dated 1/2025, documents Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. General Guidelines: 1. Pressure injuries are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. 2. The Most common site of a pressure injury is where the bone is near the surface of the body including the back of the head around th4 ears, elbows, should blades, backbone, hips, knees, heels, ankles, and toes. 5. Once a pressure injury develops, it can be extremely difficult to heal. Pressure injuries are a serious skin condition for the resident. Interventions and Preventative Measures: 1. Identify risk factors for pressure injury development. Additional Factors that Indicate Residents at Risk: The following are additional clinical conditions, treatments, and abnormal lab values that indicate that a resident is at risk for pressure injuries. 1. Impaired/decreased mobility and decreased functional ability; 2. Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; 6. Cognitive Impairment; 7. And Malnutrition, and hydration deficits. Equipment and Supplies: The following equipment and supplies will be necessary when providing preventive skin care. 1. Tools for assessing skin and pressure injury risk: a. Braden Risk Assessment Form. b. Intervention Preventive Measures.The facility's Skin and Wound Care Management, dated 11/28/2017, documents Guidelines: 8. Preventative measures, such as barrier creams, can be employed to help maintain skin integrity as well as utilization of pressure relieving surfaces, floating heels, protective boots, and use of positioning devices.R1's Face Sheet, dated 7/16/25, documents R1 is a [AGE] year-old male that admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Cerebral Palsy, Epilepsy, Unspecified Intellectual Disabilities, and Hypothyroidism.R1's MDS (Minimum Data Set) Assessment, dated 7/1/25, documents R1 is dependent with all Activities of Daily Living, is at risk for developing pressure ulcers, and has one stage 2 unhealed pressure ulcer.R1's Full Clinical/Body Observation, dated 5/15/25, documents R1 had no skin alterations/pressure ulcers.R1's Braden Scale Pressure Risk Assessment, dated 5/19/25, documents R1 was a very high risk for pressure ulcer development.R1's Initial Wound Evaluation and Management Summary, dated 6/30/25 and signed by V14/Wound Physician, documents Chief Complaint: (R1) presents with a wound on his right posterior heal. Stage two Pressure Wound of the Right, Posterior Heel Partial Thickness: Etiology: Pressure. Stage: 2. Duration: Less than one day. Wound Size: 4.5cm (Centimeters) x 5.0cm x Not Measurable. Exudate: None. Dermis: Open areas with exposed dermis. Blister: Fluid Filled. Additional Care Plan Items. Pressure Off-Loading Boot.R1's Wound Management Detail Report, dated 7/14/25 and signed by V4/Wound Nurse, documents an in house acquired stage two pressure ulcer was identified on 7/1/25 to R1's right heel. This same report documents, Date Observed: 7/14/25. Length 4.5cm (Centimeters) x Width 5.0cm x Depth 0. 0cm. Exudate Amount: None. Tissue Type: Closed/Resurfaced.R1's current Care Plan does not document an intervention to apply a pressure relieving off-loading boot to R1's right heel.On 7/14/25 from 1:05 PM through 1:15 PM R1 was sitting in his wheelchair in the dining room. R1's right foot was observed to have a sock on and R1's right heel was resting on his right foot pedal of his wheelchair.On 7/15/25 at 11:32 AM R1 was sitting in the dining room in his wheelchair. R1's right heel observed to have a tennis shoe on and was resting on his right wheelchair foot pedal.On 7/16/25 at 10:12 AM V4/Wound Nurse prepared treatment to R1's right heel. R1's right heel area observed to be approximately a quarter in size. No drainage observed. On 7/16/25 at 12:05 PM V4/Wound Nurse stated, (R1) has a facility acquired pressure ulcer stage 2 to his right heel. (R1's) right heel area was caused by pressure. (R1) should be wearing a pressure relieving boot to his right heel but it sometimes would make his heel slide off his foot pedal. I did not let (V14/Wound Physician) know that we were not following her recommendation to apply a pressure relieving boot to (R1's) right heel. We (the facility) should still be offloading (R1's) heel or applying his pressure relieving boot and haven't been. I am responsible for updating (R1's) skin care plan. I did not update (R1's) skin care plan with new interventions to offload (R1's) heels while in bed or to apply a pressure relieving boot to (R1's) right heel while out of bed to prevent deterioration of the right heel pressure wound and should have |

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|---|---|---|---|
| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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|---|---|
| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>Lincoln, IL 62656 |

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|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to monitor an indwelling urinary catheter for urine output, urine color, and urine consistency, perform a voiding trial as ordered by a physician, follow-up with urology as ordered by a physician, and provide catheter care every shift for one of four residents (R4) reviewed for indwelling urinary catheters in the sample of 30.Findings include:The facility's Urinary Catheter Care Policy, dated 9/2005, documents Purpose: The purpose of this procedure is to prevent infection of the resident's urinary tract. Preparation: 1. Review the residents plan to assess for any special needs of the resident. 7. Maintain an accurate record of the resident's daily output, per facility policy and procedure. Documentation: The following information should be recorded in the resident's medical record- 1. The date and tie that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting or pain. 6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data.R4's Hospital Pre-admission Progress Note dated 6/26/25 documents R4 had an indwelling urinary catheter placed on 6/18/25 for the diagnoses of Urinary Retention. 'R4's Hospital Discharge Orders dated 6/25/25 document Transfer to (facility). Voiding trial in next three to five days. Follow-up with the urology for recurrent urinary retention.R4's current Physician Order Report documents R4 was admitted to the facility on [DATE] with the diagnoses of Urinary Retention.R4's current Care Plan documents, Start Date 6/25/25: (R4) requires an indwelling urinary catheter related to urinary retention. Goal: (R4) will have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma. Approach: Assess the drainage each shift. Measure and record intake and output. Provide catheter care each shift and as needed.R4's Electronic Health Record dated 6/25/25 (date of admission) through 7/15/25 does not include evidence of R4's intake and output being monitored, R4's urinary catheter drainage being monitored each shift, or R4's urinary catheter care being performed every shift. This same record also does not include evidence of a voiding trial being completed as ordered or a follow-up with urology.On 7/15/25 at 12:20 PM R4 was lying in bed with an indwelling urinary catheter bag hanging on the left side bed frame. R4's urinary catheter tubing had brown dried debris located at the insertion site. R4 stated staff do not clean his catheter tubing daily.On 7/16/25 at 1:00 PM V19 (Regional Nurse Consultant) verified R4's voiding trial and follow-up with urology did not get completed as ordered, and the facility did not monitor R4's intakes and outputs, urinary drainage, or provide urinary catheter care every shift. |

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| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>Lincoln, IL 62656 |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to update weight loss care plans with weight loss interventions for two of four residents (R1 and R16) reviewed for significant weight loss in the sample of 30.Findings include:The facility's Weight Assessment and Intervention Policy, dated 1/2025, documents The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month- Five percent weight loss is significant; greater than 5% is severe. b. 3 months- 7.5 percent weight loss is significant; greater than 7.5% is severe. c. 6 months- 10 percent weight loss is significant; greater than 10 percent is severe. Care Planning: 2. Individualized care plans shall address to the extent possible: a. The identified causes of weight loss; b. Goals and benchmarks for improvement; and c. Time frames and parameters for monitoring and reassessment.1. R1's Face Sheet, dated 7/16/25, documents R1 is a [AGE] year-old male that admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Cerebral Palsy, Epilepsy, Unspecified Intellectual Disabilities, Hypothyroidism, Bradycardia, and Dysphagia, and Gastrostomy Status Placed 4/30/25.R1's MDS (Minimum Data Set) Assessment, dated 7/1/25, documents R1 had a significant weight loss of 5 or more percent in one month and/or 10 percent or more in 6 months and is not on a physician-prescribed weight loss regimen.The facility's Weight Variance Report, dated 1/1/25 through 7/9/25, documents R1 weighed 126.2 pounds on 6/3/25 and 109.60 pounds on 7/1/25 indicating R1 had a significant weight loss of 13.2 percent weight loss in one month.R1's current Physician Orders documents R1 has a physician order to receive a magic cup (Nutritional Supplement) daily and Prostat (Nutritional Supplement) 30 milliliters twice a day to promote weight/protein status.R1's current Care Plan does not include updated weight loss interventions to prevent further weight loss of a magic cup and Prostat after a significant weight loss was identified on 7/1/25.2. R16's Face Sheet, dated 7/16/25, documents R16 is a [AGE] year-old male that admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Quadriplegia, Cerebral Infarction, Alzheimer's, Type Two Diabetes Mellitus, and Major Depressive Disorder. The facility's Weight Variance Report, dated 1/1/25 through 7/9/25, documents R16 weighed 156.40 on 1/6/25 and 130.40 on 7.3.25 indicating a significant weight loss of 16.6 percent in 6 months and weight 137. 60 on 6/2/25 and 130.40 indicating a significant weight loss of 5.2 percent in one month.R16's current Physician Orders documents R16 has a physician order to receive Prostat 45 milliliters (Nutritional Supplements) twice a day and double portions at all meals to promote weight/protein status.R16's current Care Plan documents R16 is at risk for malnutrition. This same plan of care does not document updated weight loss interventions to prevent further weight loss of Prostat 45 milliliters twice a day and double portions at all meals after a significant weight loss was identified on 7/3/25 of 5.2 percent in one month and 16.6 percent in 6 months.On 7/16/25 at 1:19 PM V10/Dietary Manager stated she is responsible for updating dietary care plans for residents who are identified for significant weight losses and have new physician ordered nutritional interventions. V10 verified she did not update R1's nutritional care plan with new nutritional interventions after a significant weight loss was identified on 7/1/25 or R16's nutritional care plan with new nutritional interventions after a significant weight loss was identified on 7.3.25. V10 stated, I should have updated both (R1) and (R16's) nutritional care plan with new physician ordered weight loss interventions when the significant weight losses were identified to prevent further weight loss. I just haven't got that far yet. |

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| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>Lincoln, IL 62656 |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>(continued on next page) |

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| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>Lincoln, IL 62656 |

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|---|---|
| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer prescribed opioid medications to keep residents' pain controlled, failed to perform pain assessments and implement pain relieving interventions while the residents were not receiving their prescribed pain relieving opioid medications, and failed to notify the physician of the need for a opioid medication refill order and complaints of increased pain for three of three residents (R2, R14, and R22) reviewed for pain in the sample of 30. These findings resulted in R2 experiencing restlessness and unrelieved pain after seven days of going without his prescribed opioid medication, R14 experiencing excruciating and stabbing unrelieved pain to the lower back, and R22 experiencing unrelieved severe pain to the lower back and legs.Findings include:The facility's Pain Management Policy, dated 1/2025, documents Purpose: To establish a program with a multi-level approach to pain management to assist the facility in delivering safe, individualized pain care. Policy: It is the policy of the facility to facilitate resident safety, independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish the goals through an effective pain management program. Definition: The facility will utilize a consistent pain assessment. The resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital sign changes, and changes in behavior and mood will be used to determine the presence of pain. Standards: 1. Pain assessment protocol may be initiated under any of the following situations: Any indication of pain based on the Pain Assessment performed for each resident at the time of admission, quarterly and with any condition change associated with the potential of pain, when the Minimum Data Set triggers an indication of pain (section J2, J3), Resident received routine pain medication and/or pain is not controlled, a change in a resident condition occurs to require pain control, A significant increase in the need for use of as needed use of pain medication, and a change in pain identification related to behavior, cognition or mood. 5. An interdisciplinary process and care plan will be developed and implemented based on the assessed findings, pain rating scale, and pain relieve strategies (interventions). 7. Care plans will be reviewed and updated each time the resident's pain management plan is found not to be effective and at least each quarterly care conference. 11. Documentation of assessments and the resident's response to the pain management plan will be made with each assessment. 12. The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medications.The facility's Physician Orders policy dated 1/23/25 documents, Nursing staff will follow physician orders. In an event where a resident refused medication, or mediation is not available physician or nurse practitioner will be notified.1. R2's admission Care Plan dated 7/3/25 documents, (R2) is at risk of complaints of chronic pain related to infection/inflammatory reaction due to internal fixation with removal of hardware and pressure ulcers. (R2) has narcotic and non-narcotic pain medications orders prn (as needed). Approach: Administer medications as per orders. Evaluate/record/report effectiveness and any adverse side effects.R2's current Physician Order Report documents R2 was admitted on [DATE] with the diagnoses of a Pressure Ulcer of the right hip, Osteomyelitis, Pressure ulcer of the left hip, Pressure Ulcer of the right buttock, Contracture of Right Hip, Contracture of the right knee, Contracture of right lower leg muscle, Infection and inflammation reaction due to internal fixation device, and Anxiety Disorder. This same Physician Order Report documents, Start Date 6/30/25 (Admission) Hydrocodone-Acetaminophen (Norco) 10-325 mg (milligrams) one tablet every eight hours as needed.R2's Pharmacy Packing Slip dated 7/7/25 documents R2's Hydrocodone/Acetaminophen 10-325 mg 30 tablets was not delivered until 7/7/25 (seven days after R2 was admitted to the facility).R2's Medication Administration Records (MARs) dated 6/30/25 through 7/7/25 document R2 did not receive any Norco as ordered during this timeframe. R2's Electronic Health Record does not include documentation of R2's Physician (V30) being notified of the need for a prescription to fill R2's Norco, or documentation of pain relieving interventions utilized while R2 was not receiving his Norco as ordered from 6/30/25 through 7/7/25.R2's Progress Notes dated 7/5/25 at 3:45 PM and signed by V28 (Agency RN/Registered Nurse) documents, (R2) alert with confusion. Very confused on (R2's) whereabouts and day to day things. (R2) very restless at times. (R2) throws his legs and upper half of body out of the bed. Staff repositioned (R2) very frequently. (R2) is however contracted. (R2) has legs drawn up in a fetal position. (R2) frequently yells out for someone to get the people out of there while he points at |

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|---|---|---|---|
| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>Lincoln, IL 62656 |

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| F 0755<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

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| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

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|---|---|
| F 0755<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement a process for the timely ordering and reordering of medications, failed to notify the physician of the need for opioid analgesic medications and anti-anxiety medication prescription refill orders, failed to notify the physician of the need for an alternative to ordered Ozempic, and failed to obtain physician ordered opioid analgesic medications, anti-antianxiety medication, and weight-loss medication from the pharmacy for four of four residents (R2, R14, R18, and R22) reviewed for pharmacy services in the sample of 30. These findings resulted in R2 experiencing restlessness, increased anxiety, and unrelieved pain after seven days of going without his prescribed opioid medication and anti-anxiety medication, R14 experiencing excruciating and stabbing unrelieved pain to the lower back and withdrawal symptoms, and R22 experiencing unrelieved severe pain to the lower back and legs. Findings include: The facility's Controlled Substance Prescription Pharmacy Policy, dated 10/25/2014, documents Policy: Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. To facility effective communication, documentation, and aide in prevention of medication errors, medication orders should be clear and concise and free of potentially dangerous abbreviations. Procedures: A. Elements of a controlled substance prescription: 12) Manual signature of prescriber. C. The prescriber and/or nurse are contacted for direction when delivery of a medication will be delayed, or the medication is not or will not be available. E. New Controlled Substance Prescriptions: 1) For emergency-controlled substance orders, the nurse will review the Emergency Kit list for available medications prior to contacting the prescriber. The nurse will communicate to the prescriber the emergency medications available to provide appropriate care to the patient. 4) In order to communicate Controlled II orders orally/verbally between the prescriber and pharmacist, the prescription must meet DEA's (Drug Enforcement Administration) criteria of an emergency situation. Conformance with such criteria must be discussed between the prescriber and pharmacist and documented on the prescription: a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user. b. No appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II; AND c. It Is not reasonably possible for the prescriber practitioner to provide written prescription to be present to the person dispensing the substance prior to dispensing. 4) Only after verifying that the above communication has occurred and the pharmacy and facility receive a complete prescription, the nurse reviews the Emergency Kit List to assess the contents. After finding the medication list, the nurse unlocks the container seal and removes the required medication if it is available in the emergency kit. If the medication is not available in the emergency kit, the nurse contacts the pharmacy using the afterhours emergency number(s) if necessary. (See IC5: Emergency Pharmacy Service and Emergency Kits). The United States Food and Drug Administration Safety Communication Website article dated 4-9-19 documents, Opioid's are a class of powerful prescription medicines that are used to manage pain when other treatments and medicines cannot be taken or are not able to provide enough pain relief. Patients taking opioid pain medicines long-term should not suddenly stop taking your medicines without first discussing with hour health care professional a plan for how to slowly decrease the dose of the opioid and continue to manage your pain. Even when the opioid dose is decreased gradually, you may experience symptoms of withdrawal. Rapid discontinuation can result in uncontrolled pain or withdrawal symptoms. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide. 1. R2's admission Care Plan dated 7/3/25 documents, (R2) is at risk of complaints of chronic pain related to infection/inflammatory reaction due to internal fixation with removal of hardware and pressure ulcers. (R2) has narcotic and non-narcotic pain medications orders prn (as needed). Approach: Administer medications as per orders. Evaluate/record/report effectiveness and any adverse side effects. R2's current Physician Order Report documents R2 was admitted on [DATE] with the diagnoses of a Pressure Ulcer of the right hip, Osteomyelitis, Pressure ulcer of the left hip, Pressure Ulcer of the right buttock, Contracture of Right Hip, Contracture of the right knee, Contracture of right lower leg muscle, Infection and inflammation reaction due to internal fixation device, and Anxiety Disorder. This same Physician Order Report documents, Start Date 6/30/25 (Admission) Hydrocodone-Acetaminophen (Norco) 10-325 mg (milligrams) one tablet every eight hours as needed.R2's admission Physician's Orders dated 6/30/25 document, Lorazepam 0.5 mg twice daily as needed for Anxiety.R2's Pharmacy Packing Slip dated |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145719 | A. Building<br>B. Wing | 07/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lincoln Village Healthcare | 2202 North Kickapoo Street<br>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 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>Based on record review and interview the facility failed to obtain a physician ordered Basic Metabolic Panel for one of five residents (R19) reviewed for laboratories in the sample of 30.Findings include:The facility's Physician Orders policy dated 1/23/25 documents, Nursing staff will follow physician orders.R19's current Physician Order Report documents, Start Date 1/15/25: Basic Metabolic Panel every Wednesday every two weeks.R19's Medical Record dated 1/15/25 documents R19 has only had a Basic Metabolic Panel laboratory obtained on 6/25/25, 7/2/25, 7/4/25, and 7/9/25. On 7/16/25 at 11:00 AM V19 (Regional Nurse Consultant) verified R19 did not have a Basic Metabolic obtained every two weeks as ordered on 1/25/25. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions during direct cares for one of five residents (R22) reviewed for infection control in the sample of 30.Findings include:The facility's Enhanced Barrier Precautions policy dated 01/2025 documents, Guideline: It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms. Enhanced Barrier Precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents know to be colonized or infected with a MDRO (Multi-Drug-Resistant Organism) as well as those at increased risk of MDR acquisition. Implement Enhanced Barrier Precautions for residents with any of the following: Wounds and/or indwelling devices. High-contact resident case activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.R22's current Physician Order Report documents R22 has the diagnoses of a Colostomy, a Pressure Ulcer of right buttock, and an Indwelling Urinary Catheter.R22's current Care Plan documents, Problem start date 6/10/25: (R22) requires Enhanced Barrier Precautions related to indwelling urinary catheter, colostomy, and open wound on right ischium. Goal: Enhanced Barrier Precautions will reduce the spread of the infectious agent, minimize the transmission of the infection, and reduce the risk of colonization through next review. Approach: Gown and glove use when performing high-contact resident contact activity.On 7/16/25 at 11:00 AM R22 was lying in bed and had an Enhanced Barrier Precautions sign posted on his doorway to his room. V29 (CNA/Certified Nursing Assistant) had gloves on and was emptying stool out of R22's colostomy into a urinal. V29 was not wearing a gown while emptying R22's colostomy bag stool.On 7/16/25 at 12:10 PM V29 stated, I should have worn a gown when emptying the stool out of (R22's) colostomy bag. I guess I just forgot.On 7/16/25 at 12:15 Pm V11 (Infection Preventionist) stated V29 should have worn a gown when emptying R22's colostomy bag. |