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	09/11/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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:	(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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to protect a wound from insect contamination and failed to provide appropriate physician ordered wound care leading to a decline in the Resident's physical well-being for one of three Residents (R1) reviewed in sample of five. This failure resulted in R1 requiring emergent transport to the local hospital and hospitalization. Findings include:The Facility Pressure/Skin Breakdown-Clinical Protocol Policy, reviewed 1/2025, documents: document the individual's significant risk factors; nurse must document/report a full assessment of skin condition; identify factors contributing or predisposing Residents for skin breakdown such as co-morbidities; document signs/symptoms of infection, skin condition assessment and the impact of co-morbid conditions on wound healing; and the physician will authorize pertinent orders related to wound treatments.The Facility Resident Rights for People in Long-Term Care Facilities, dated 11/2018, documents: the Facility must provide services to keep your physical and mental health, at their highest practical levels; and the Facility must be safe, clean, comfortable and homelike. The Facility Licensed Practical Nurse/LPN Job Description, undated, documents: to provide nursing care to Residents under the supervision of a Registered Nurse/RN and in accordance with federal, state and Facility standards; responsible for administering medications, performing treatments, monitoring Resident's health status and supporting the overall care plan to promote optimal health outcomes; administer treatments as prescribed in accordance with Facility policies and state regulations; monitor Resident's health status, observe for changes in condition and promptly report finding to the Registered Nurse or Physician; follow infection prevention and control procedures; maintain a safe environment for Residents; and comply with all state, federal and Facility regulations.R1's Physician Order Report, dated 8/1/25 through 8/31/25, documents diagnoses including Chronic Osteomyelitis, Anxiety, Anemia, Type Two Diabetes Mellitus with other skin complications, Atherosclerotic Heart Disease, Chronic combined Systolic and Diastolic (Congestive) Heart Failure, Alcohol dependence with withdrawal, Hypertension and Hyperlipidemia. The Physician Order Report documents Physician orders for: arterial ultrasound to bilateral feet for non-healing wounds (dated 7/24/25); Enhanced Barrier Precaution (dated 7/23/25); Left Foot and Right Foot cleanse with wound cleanser, dry well, apply skin barrier to necrotic areas, place topical medication (Calcium Alginate) to open area on Left Posterior Ankle and Right Medical Second Toe and Great Toe, and cover with dry dressing (Army Battle Dressing/ABD and Kerlix) every day (start date 7/1/25 and end date 8/4/25); and Bilateral Foot wounds topical medication (betadine) and open to air every day (start date 7/25/25 and end date 9/4/25). The Physician Order Report does not document a dry dressing order for 8/7/25 or 8/8/25.R1's Treatment Administration Record/TAR, dated 8/1/25 through 8/31/25, documents an order to R1's Right Foot and Left Foot to cleanse area with wound cleanser, dry well, apply skin barrier to necrotic areas, place topical medication (Calcium Alginate) on open area between right medial second toe and great toe and Left Posterior Ankle) and cover with dry dressing (ABD and Kerlix wrap) every shift (start date 7/1/25 and end date 8/4/25).R1's Treatment Administration Record/TAR, dated 8/1/25 through 8/31/25, documents an order to R1's bilateral food wounds for topical medication (Betadine) and open to air every day (start date 7/25/25 and end date 9/4/25). R1's Nursing Progress Note, dated 8/8/25 at 4:10 am, documents that R1 requires staff assistance with transfers, does not like to get out of bed, appetite poor and refused shower.On 8/8/25 at 6:00 am, V6's (Licensed Practical Nurse/Wound Nurse) Nursing Progress Note documents myiasis (maggots/larva) observed in the wound bed during treatment and located primarily in the base of the wound, within necrotic tissue. R1 was transported to the local emergency department ([NAME]).On 8/8/25 at 6:06 am, V6's (Wound Nurse) Nursing Progress Note documents R1 being transferred to the local hospital ([NAME]) by Emergency Services for evaluation due to complications related to bilateral foot wounds.R1's Nursing Note, dated 8/8/25 at 10:30 am, documents R1 being transferred from the local hospital ([NAME]) to a larger area hospital ([NAME]).R1's Nursing Note, dated 9/4/25 at 12:36 pm, documents hospital ([NAME]) report to the Facility for R1's return from the hospital back to the Facility. R1 was admitted to the larger area hospital ([NAME]) on 8/9/25 for a Urinary Tract Infection, Sepsis and Osteomyelitis. R1 underwent a Right above-the-knee amputation on 8/20/25, was placed on a feeding tube, insertion of an indwelling urinary catheter. On 9/2/25 R1 became unresponsive and a stroke alert was initiated, then R1 was recommended for Hospice services. R1's Paramedic Report/EMS, dated 8/8/25 at 7:21 am, documents that EMS was dispatched for complaints of foot ulcers with maggots. Staff (V6/LPN Wound Nurse) reported that V6 had