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	01/21/2026

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 prevent abuse for two residents of four residents (R13 and R15) reviewed for abuse in a sample of 17. Findings include:The Abuse Prevention Policy (not dated) 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 facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident 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. This facility is committed to protecting our residents from abuse, neglect, Exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Definitions - Abuse means any physical or mental injury or sexual assault inflict 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. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes all instances of abuse of residents, even those in a coma, cause physical harm or pain or mental anguish. The term willful in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 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.1. The Final Facility Incident Report Form for 11/12/25 incident documents a resident-to-resident altercation between R1 (now identified as R14) and R2 (now identified as R15). Occurrence (R15) was ambulating into the main dining room at 6:00 AM. At that time, (R14) entered the main dining room and immediately approached (R15) without any provocation from (R15). (R14) took his [NAME] and began pushing (R15) back up against the wall. (R14) then began raising his [NAME] and pushing it against (R15). (R15) then began to push back against (R14). At this point (R14) and (R15) both were using their hands to push on each other. Staff immediately responded and separated residents. (R14) stated that (R15) was irritating him and was in his business. (R15) did not say anything or display any behavior that would have been irritating. (R15) states he does not know what happened. It all happened so fast, he only knew he had gone to the main DR (dining room) to get a cup of ice and a straw. (R14) was examined immediately with no injuries noted. (R15) was exam immediately with two (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	scratches noted to his chin, in which he states he received while he was shaving himself.R14's computerized Medical Record documents that R14 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Chronic Kidney Disease (stage 3), Mild Intellectual Disabilities, Schizoaffective Disorder, Major Depressive Disorder, and Panic Disorder. R14 discharged on 11/25/25.R14's MDS (Minimum Data Set) assessment dated [DATE] documents Section C (Cognition Patterns) a BIMS (Brief Interview for Mental Status) of 15, indicating (cognition intact). Section GG (Functional Abilities) documents R14 has no upper or lower extremity impairment and uses a Walker. R14 required set up help or supervision for all activities of daily living, bed mobility, and transfers.R14's Nursing Note dated 11/12/25 at 5:45 AM, documents that R14 was involved in peer-to-peer altercation. R14 was placed with one-to-one observation with staff. R14 continued to yell at staff and refused redirection to his room. R14 states He (R15) got in my business.R15's computerized Medical Record documents that R15 is a [AGE] year-old that admitted to the facility on [DATE] with a diagnosis of Alcohol Dependence with Alcohol Induced Persisting Dementia.R15's MDS (Minimum Data Set) assessment dated [DATE] Section C (Cognitive Patterns) documents a BIMS (Brief Interview for Mental Status) of 15, indicating (cognition intact). Section GG (Functional Abilities) documents R15 has no upper or lower extremity impairment, does not use any devices to ambulate, requires set up help or supervision for all activities of daily living, bed mobility, and transfers. R15's Nursing Note dated 11/12/15 at 11:01 AM written by V2/Director of Nursing documents that R15 spoke to R15's family about the incident. R15 had an abrasion on his forehead and denied having any pain.On 1/21/26 at 9:45 AM, R15 stated that one morning (date not given) he was walking into the dining room and another resident (identified as R14) was walking with a [NAME] towards R15. For no reason (R14) took both hands off (R14's) [NAME] and shoved R15 in the chest with both hands as R15 walked by (R14). This caused R15 to drop the cup he was carrying, and the contents spilt on the floor. R15 was trying to keep (R14) away from him by trying to push (R14) away but (R14) kept pushing the [NAME] towards R15 pushing R15 against a wall. The staff came and took (R14) away from R15. R15 stated that he was not hurt but he thought it was an act of violence by the other resident (R14). R15 also stated I didn't like (R14) pushing me but I'm glad it was me and not a resident that might have fallen. R15 then lifted his metal cup with a lid showing this surveyor how the cup was dented when it was dropped during the incident with (R14).On 1/21/26 at 1:30 PM, V2/Director of Nursing stated that on 11/12/25 at 5:45 AM, V2 had just entered the building and heard scuffling coming from the dining room. V2 went to see what was happening and R14 was pushing against R15. R15 had dropped his cup on the floor and there was liquid on the floor. R14 and R15 were separated. R15 had a scratch on his face but V2 cannot say for sure if the scratch happened during the incident between R14 and R15 or not.2. The Final Facility Incident Report Form for 12/18/25 incident documents a resident-to-resident altercation between R1 (now identified as R12) and R2 (now identified as R13) witnessed by staff. (R12) was sitting in the dining room in her normal location. (R13) was sitting in the dining room in her normal location conversating with other residents as she typically was. Both residents were waiting for dinner to be served. (R12) picked up a saltshaker and tossed it in the direction of (R13). The saltshaker made contact with (R13). R12's computerized Medical Record documents that R12 is an [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Dementia, Anxiety, Major Depressive Disorder, Irritability and Anger,R12's MDS (Minimum Data Set) assessment dated [DATE] Section C (Cognitive Patterns) documents a BIMS (Brief Interview for Mental Status) of 2, indicating (severe cognitive impairment). Section GG (Functional Ability) documents R12 has upper and lower extremity impairment on both sides, uses a wheelchair, requires set (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up help for eating, is dependent on staff for all activities of daily living, bed mobility, and transfers. R12's Nursing Note dated 12/18/25 at 4:20 PM, documents that R12 became agitated with peer (R13) and threw a salt and pepper caddy at peer.On 1/21/26 at 1:15 PM, R12 was sitting in her room. R12 was unable to answer questions appropriately.R13's computerized Medical Record documents that R13 is an [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Polyarthritis, Transient Cerebral Ischemic Attack, Essential (Primary) Hypertension, and Mild Intellectual Disabilities.R13's MDS (Minimum Data Set) assessment dated [DATE] Section C (Cognitive Patterns) documents a BIMS (Brief Interview for Mental Status) of 7, indicating (severe cognitive impairment). Section GG (Functional Abilities) documents R13 has no upper or lower impairments, requires supervision for all activities of daily living, bed mobility, and transfers.R13's Nursing Note dated 12/18/25 at 7:35 PM, documents that R13 had a peer throw a salt container at R13 hitting in R13 in her lower back. R13 assessed at this time with no complaints.On 1/21/26 at 10:42 AM, R13 was sitting in the dining room with R16. R13 stated that she was hit in the back by R12 when R12 threw a plastic container at her. R13 stated that it made her back hurt, and she does not like to be around R12.On 1/21/26 at 10:42 AM, R16 was sitting in the dining room across from R13. R16 stated that he was sitting with R13 when R12 threw the plastic container that holds the sugar at R13. The container hit R13 in the back. R16 also stated that he thought R12 intentionally meant to hit R13.On 1/21/26 at 1:30 PM, V2/DON stated that she had heard yelling in the dining room (date unknown) and when V2 got to the dining room staff were intervening in an incident that had happened between R12 and R13. R12 had thrown a plastic container that holds sugar packets at R13 hitting R13 on R13's back. R13 had no sign of injury but did complain of back pain. :