

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145719	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/24/2026
NAME OF PROVIDER OR SUPPLIER  Lincoln Village Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to notify a physician timely regarding frequent refusals of a (mood stabilizer) medication for one of three residents (R3) reviewed for physician notification of change in a sample of seven. Findings include: The facilities Medication Administration Policy, dated 10/25/2014, documents, B. Administration: 2) Medications are administered in accordance with written orders of the prescriber. C. Refusals of Medication: 5) Medication refusals must be reported to the prescriber after (XX) number of doses are refused and there must be documentation of prescriber notification of such. D. Documentation (including electronic): 6) If (XX consecutive doses) of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response. R3's Face Sheet documents R3 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Schizoaffective Disorder, Major Depressive Disorder, Panic Disorders, and Mild Intellectual Disabilities. R3's Care Plan documents Problem Start Date: 2/27/25- (R3) takes Depakote as a mood stabilizer for aggressive mood. Interventions: Nursing to monitor for any adverse reactions to Depakote and report to MD (Doctor of Medicine). Staff to monitor, document, and report any symptoms of schizoaffective disorder to MD. Problem Start Date: 2/27/25- (R3) exhibiting change in usual behavior as evidenced by increased restlessness, fidgety, lack of initiative/involvement, and being irritated. Interventions: Evaluate whether the behavior is attributable to organic causes or other risk factors. R3'S MDS (Minimum Data Set) Assessment, dated 10/2/25, documents R3 is moderately cognitively impaired and a behavior of rejection of cares such as refusal of medications. R3's Physician Orders, dated 11/12/26, documents Start Date: 7/9/2022- Depakote (mood stabilizer) 500mg (milligrams) take one tablet three times a day. R3's MAR (Medication Administration Record) dated September 1st, 2025, through September 30th, 2025, documents R3 refused his Depakote (mood stabilizer) 23 times out of 90 doses. R3's MAR dated October 1st, 2025, through October 31st, 2025, documents R3 refused his Depakote (mood stabilizer) 27 times out of 93 doses. R3's MAR dated November 1st, 2025, through November 12th, 2025, documents R3 refused his Depakote (mood stabilizer) 7 out of 37 doses. R3's Electronic Medical Record does not include documentation of R3 refusing his Depakote on multiple occasions from September 1st, 2025, to November 12th, 2025. On 1/24/26 at 10:47 AM V18/R3's Physician stated he was not aware that R3 had missed 57 doses of Depakote from October 1st, 2025, to November 12th, 2025. V18 stated, This is the first I am hearing about (R3) refusing and not receiving his medications. I don't remember being notified of that ongoing problem. I would absolutely want to be notified of (R3's) refusals of medications and especially (R3's) Depakote. I would want to be notified if any resident was refusing medication on a regular basis. On 1/24/26 at 11:17 AM V1/Administrator verified the facility's Medication Administration Policy, dated 10/25/14, does not document the number of doses that can be missed before the doctor should be notified. On 1/24/26 at 12:02 PM V2/Director of Nursing verified</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 145719	If continuation sheet Page 1 of 2

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3 was refusing his noon dose of Depakote on a regular basis and stated she would expect the nurses to notify a resident's physician of any refusals of medication by a resident. V2 verified there was no documentation in R3's medical record of physician notification of R3 refusing his Depakote during the period of October 1st, 2025, to November 12th, 2025.</p>