

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2025
NAME OF PROVIDER OR SUPPLIER St Clara's Rehab & Senior Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 Castle Manor Drive 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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility failures resulted in two deficient practices.A. Based on record review and interview the facility failed to provide skin treatments as ordered by the physician for two of three residents (R1 and R2) reviewed for skin alterations in the sample of three.B. Based on record review and interview the facility failed to obtain blood sugars as ordered by the physician for one of three residents (R2) reviewed for blood sugar monitoring in the sample of three.Findings include:A. The facility's Wound and Ulcer policy dated 3/28/24 documents, It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. Procedure: Initiate the treatment protocol appropriate for the stage of ulcer or for the wound assessment. Document wound/ulcer treatment provision on the treatment administration record. Treatment continues per the physician orders until the wound and/or ulcer is healed.1.R1's Physician Order Summary Reports and TARs (Treatment Administration Records) dated 6/1/25 through 8/22/25 document, Start date 12/13/24 Emollient ointment apply to BUE (Bilateral Upper Extremities) every shift for dry skin. Start date 6/19/25 apply barrier cream to buttocks once daily and as needed for wound prevention.R1's TARs dated 6/1/25 through 8/22/25 document R1 did not receive the emollient ointment to the BUE as ordered on five occasions and R1 did not receive the barrier cream to the buttocks as ordered on three occasions.On 8/23/25 at 10:15 AM V2 (Director of Nursing/DON) verified that according to R1's TARs dated 6/1/25 through 8/22/25 R1 did not receive the emollient ointment to the BUE as ordered on five occasions and R1 did not receive the barrier cream to the buttocks as ordered on three occasions.2. R2's Physician Order Summary Reports and TARs (Treatment Administration Records) dated 6/1/25 through 8/22/25 document, Start date 11/12/24 skin preparation to left heel daily every night shift. Start date 6/18/25 cleanse wound, apply triple antibiotic ointment, abdominal pad, and wrap until healed every day (left forearm). Start date 7/30/25 cleanse areas, apply xeroform (petroleum dressing), abdominal pad, and (rolled gauze) to left arm every day until healed. R2's TARs dated 6/1/25 through 8/22/25 document R2 did not receive the skin preparation to the left heel as ordered on two occasions, R2 did not receive the triple antibiotic, abdominal pad, and wrap to the left forearm as ordered on one occasion, and R2 did not receive the petroleum dressing, abdominal pad, and rolled gauze to the left arm on three occasions.On 8/23/25 at 10:15 AM V2 (DON) verified that according to R2's TARs dated 6/1/25 through 8/22/25 R2 did not receive the skin preparation to the left heel as ordered on two occasions, R2 did not receive the triple antibiotic, abdominal pad, and wrap to the left forearm as ordered on one occasion, and R2 did not receive the petroleum dressing, abdominal pad, and rolled gauze to the left arm on three occasions.B. The facility's Blood Glucose Testing and Monitoring policy dated 8/2024 documents, Policy: Blood glucose levels will be monitored and obtained per licensed health care practitioner's orders. Blood glucose testing it to be performed by a licensed nurse.R2's Physician Order Summary Reports and MARs (Medication Administration Records) dated 6/1/25 through 8/22/25 document, Start Date 1/26/25 (Blood Glucose Testing) before meals and at bedtime. Diagnosis Type II Diabetes Mellitus.R2's MARs dated 6/1/25 through 8/22/25 document R2's blood glucose testing was not obtained as ordered by the physician on 6/29/25 at 11:30 AM and 7/2/25 at 5:00 PM.On 8/23/25 at 10:15 AM V2 (Director of Nursing) verified R2's blood glucose was not obtained as ordered on 6/29/25 at 11:30 AM and 7/2/25 at 5:00 PM.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and interview the facility failed to administer insulin as ordered for one of three residents (R1) reviewed for medication errors in the sample of three. Findings include: The facility's Medication Administration policy dated 1/11/2010 documents, Objective: To provide accuracy during medication pass to assure quality care for residents. Policy: It is the policy of the facility to accurately administer medication following physician's orders. Medications should be charted during the medication pass in a consistent manner before going to the next resident. R1's Physician Order Summary Reports and MARs (Medication Administration Records) dated 6/1/25 through 8/22/25 document, Start Date 6/13/25 Insulin Aspart insulin inject 15 units subcutaneously before meals related to Type II Diabetes Mellitus. Insulin Apart insulin per sliding scale subcutaneously before meals and at bedtime related to Type II Diabetes Mellitus. If 0-150 (blood glucose) = (equals) 0 units. 151-200 = 2 units. 201-250 = 4 units. 251-300 = 6 units. 301-350 = 8 units. 351-400 = 10 units. Start Date 7/22/25 Humalog insulin 15 units subcutaneously before meals for Diabetes Mellitus. R1's MARs dated 6/1/25 through 8/22/25 document R1's Insulin Aspart 15 units was not administered as ordered by the physician on 6/18/25 at 4:30 PM, 6/24/25 at 4:30 PM, 6/29/25 at 4:30 PM, 7/12/25 at 4:30 PM, and 7/13/25 at 4:30 PM. R1's MARs dated 6/1/25 through 8/22/25 document R1's blood sugar on 7/12/25 was 188 and R1's Aspart insulin 2 units sliding scale was not administered at 4:30 PM as ordered by the physician. R1's MARs dated 6/1/25 through 8/22/25 document R1's Humalog insulin 15 units was not administered as ordered by the physician on 7/27/25 at 5:30 PM, 8/9/25 at 5:30 PM, 8/13/25 at 5:30 PM, and 8/19/25 at 5:30 PM. On 8/22/25 at 1:20 PM V5 (R1's Physician) stated, (R1) should receive her insulin as ordered. On 8/23/25 at 10:15 AM V2 (Director of Nursing) verified that according to R1's MARs R1 did not receive Aspart insulin as ordered on 6/18/25 at 4:30 PM, 6/24/25 at 4:30 PM, 6/29/25 at 4:30 PM, 7/12/25 at 4:30 PM, and 7/13/25 at 4:30 PM, and R1 did not receive Humalog insulin as ordered 7/27/25 at 5:30 PM, 8/9/25 at 5:30 PM, 8/13/25 at 5:30 PM, and 8/19/25 at 5:30 PM. V2 also confirmed that R1 not receiving her insulin as ordered is considered a medication error.</p>		