STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146114	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lena Living Center	1010 South Logan Street Lena, IL 61048

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on interview and record review the facility failed to treat a resident with respect and dignity. This applies to 1 of 6 residents (R1) reviewed for resident rights in the sample of 6. The findings include: R1's face sheet shows he is a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including cellulitis, COPD, weakness, and dehydration. On 9/30/24 at 10:55 AM, V7 (Certified Nursing Assistant-CNA) said on 9/19/24 she was receiving report from V5 (CNA). V5 told her rudely, she took away R1's call light last night because his call light was going off frequently. V5 reported R1 had soft touch call light that kept going off and she was not going to go in his room every 15 minutes. When she went to get R1 up from his bed. R1 said the girl last night (V5) took his call light away from him. He said what if I needed help and couldn't get it. R1's call light was under his bed on the floor. Staff should make sure a residents call light is within reach before leaving the room. On 9/30/24 at 12:00 PM, V6 (CNA Supervisor) said she was helping staff transfer R1 with the mechanical lift. R1 reported V5 the night CNA threw his call light under the bed because she was frustrated and took it away. She found R1's call light under his bed. Call lights should be within reach of the resident. On 9/30/24 at 11:44 AM, V2 (DON) said she was notified about the incident regarding R1. She interviewed R1 and his call light was removed out of his reach. R1 was alert and oriented and needed staff assistance with ADL's. After interviewing the staff, they confirmed the same story and R1's call light was found under his bed. V5 was terminated for poor customer service. That is not proper care or treatment of a resident. (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Incident Report dated 9/24/24 documents on Wednesday September 18th, 2024, V5 (CNA) was assigned to the C/D hall and the care of R1. V5 stated R1 had access to a sensitive call light, and it is her belief that she should have moved it out of the space where it could be accidentally bumped yet had it close enough that he could use it. On 09/20/2024, R1 stated that his call light was turned on multiple times throughout the evening and about 50% of them were by accident. This resident has a touch button call light available to him. The resident also stated that V5 was getting agitated with him due to the excessive calls and she said something along the lines of I'm taking this, there's no excuse. R1 stated that he doesn't remember where his call light was after it was taken away from his close reach. The conclusion of the facility investigation: 09/23/24 V5's employment as a Certified Nurse Aide was terminated based on inappropriate conduct. The Facility's Quality of Life Dignity, Resident Rights Policy states, each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Resident rights will be maintained during care in our facility. Any potential resident rights notification will be reported immediately to the administrator .staff shall speak respectfully to residents at all times .