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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146123	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lacon Rehab and Nursing	401 9th Street Lacon, IL 61540

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to implement menus that addressed residents' dislikes for two of six residents (R5 and R6) in a sample of seven. Findings include: The facility's substitutions policy, revised 12/30/24, documents that residents' likes and dislikes will be considered when making substitutions.On 2/20/26 at 12:20pm, R5 was sitting at the dining room table with a plate of baked fish, broccoli, hash brown casserole, and baked apples. R5 looked at the meal for several minutes, then finally asked V6, Nursing Assistant/Housekeeper, for some tartar sauce. R5 used three packages of tartar sauce on his fish. R5 stated that he does not like fish, so he is drowning the taste in tartar sauce so he can eat it. R5 stated that if he doesn't eat this, then he won't get anything. R5 stated that the substitute is always peanut butter and jelly, which he does not like either. R5 also stated that peanut butter and jelly is not a good substitute for the main meal of the day. R5 ate his meal but did not eat his baked apples. R5 stated that he does not like them either. R5 was not offered a substitute for the dessert. On 2/2/26 at 12:25pm, R6's tray sat on the dining room table opened. R6 was not in the dining room. V6 entered the dining room and stated that R6 had food delivered, so she would not be eating lunch today. 1:00pm R6 stated that she does not like fish, so she had food delivered. On 12/20/26 at 12:35pm, V5, Dietary Manager, stated that the facility does not offer an anytime menu. V5 also stated that the only substitutes available are a peanut butter and jelly sandwich or maybe a cheese sandwich. V5 verified that the substitutes are not equal in nutritional values.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to cover individual plated lunch meals during transport for three of three residents (R5, R6, and R8) reviewed for meal service in a sample of eight. Findings include: The facility's Transportation of Food policy revised 11/5/19, documents that all food being transported from the kitchen to other parts of the building must be done in a safe and sanitary manner. This form also documents that all food must be covered during transportation and that food must maintain proper temperatures while being transported. The facility's Resident Council Meeting Minutes, dated 1/8/26, documents multiple complaints about meal execution: Burnt/overcooked items (breadstick, items left in the oven), cold food (Spaghetti), undercooked/soggy eggs/omelets. The facility's Resident Council Meeting Minutes, dated 2/12/26, document multiple complaints about the execution: cold food/meals late. On 2/20/26 at 12:05pm, a cart with already-plated lunch was taken from the kitchen across the hall to the dining room. There were no covers or warmer plates to protect the main meal. The plates were then set on the table, uncovered. R5, R6, and R8 were not yet at the table. On 2/20/26 at 12:17pm, R5 propelled himself up to the dining room table in front of his open plate. R5 picked up his fish and tossed it back down on his plate. R5 stated that the food was slightly warm, but there was no one in the dining room to reheat the meal. R5 stated that it happens all the time. R6 and R8's plates sat on the table uncovered until 12:30pm, when V6, Nursing Assistant/Housekeeper, picked up the plates. V6 stated that the plates are usually covered, but she does not know why they aren't today. On 2/20/26 at 12:35pm, V5, Dietary Manager, stated that any food being transported is to be covered. V5 stated that there are several covers sitting next to the service line and does not know why the plates were not covered. V5 verified that there are no warming plates used during meal service. V5 stated that there have been complaints concerning cold food, and she is trying to change the serving process. V5 stated that with the dining rooms being so close, the meals should be plated and served as residents enter the dining room.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain the building in good repair and cleanliness for three of four (R3, R4, and R7) residents reviewed for homelike environment in a sample of seven. The facility's Homelike Environment/Maintenance policy, revised 12/1/25, documents that housekeeping and maintenance services are necessary to maintain a sanitary, orderly, and comfortable interior. This form documents that the facility is to be comfortable and have safe temperature levels. The facility's Resident Call Bells policy, revised 11/5/24, documents that the facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to centralized staff work area from each resident's bedside, toilet, and bathing facilities. The communication system shall be checked regularly to ensure operability and that it can be reached by the resident. The facility's Resident Council Meeting Minutes, dated 1/8/26, documents that Housekeeping Staffing and Cleaning Standards: Low-staff spot clean approach used: trash removal, quick sweep, mop obvious spots, wipe surfaces; deep cleaning limited. This form documents that if missed areas are observed (corners, under chairs); residents can request thorough cleaning. On 2/20/26 at 9:20am, R3's bathroom sink did not have any running water. The sink bowl had a black, slimy ring around it. There was a sign on the mirror documenting Do not turn on water. The wallpaper inside of the door was ripped off from the ceiling to about 3 feet from the floor. The missing wallpaper patch was approximately 2 feet wide. There was also a large piece of wallpaper missing from the wall next to the heating vent. V3, Assistant Maintenance Director, verified that R3's sink was not working and the wallpaper was peeled off the walls. On 2/20/26 at 9:30am, R4 was sleeping in his bed with his call light activated. V8, Certified Nursing Assistant, was walking in the hallway. V8 stated that R4's call light is always on, there is a short or something. V8 stated that he should have a handheld bell to ring if he needs assistance. V8 searched R4's room and could not find a handheld bell. V8 was asked how R4 is supposed to ask for help if he should fall, she said, I just don't know. R4's bathroom had a strong urine aroma, and the floor had a large puddle of yellowish liquid in front of the toilet. There were footprints on the floor going from the toilet to R4's bed. At 1:20pm, the bathroom floor remained wet, but there were paper towels covering the large, yellowish colored puddle on the floor. The strong urine odor remained the same. On 2/20/26 at 9:40am, R7's toilet had dry bowel movement on the seat, around the top rim of the toilet, and down the front of the toilet bowl. There was a strong smell of urine noted in his room, going into the hallway. The enabler bars appeared to have yellow and brown substance splatter on them. At 9:50am, V7, Housekeeper, stated that she was finished cleaning R7's room. V7 stated that she empties garbage, cleans the floors, and will drop off paper towels and toilet paper if needed. R7's toilet and bathroom remained the same.On 2/20/26 at 1:20pm, V9, Registered Nurse, stated that R7 will often take off his soiled briefs and leave them lying around his room. V9 stated that housekeeping is supposed to go into the room several times a day to empty the garbage. V9 verified that the rooms are to be fully cleaned, including bathrooms on a daily basis and as needed. V9 also stated that housekeeping should have cleaned the floor in R4's room.