

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Lacon Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>33970</p> <p>Based on observation, interview and record review the facility failed to allow one resident (R18) to make her own decisions of sixteen residents reviewed for choices in a total sample of fifty-seven. This failure caused R18 emotional distress and crying.</p> <p>Findings Include:</p> <p>The Facility's undated Resident Rights Policy and Procedure documents Self-determination. Every resident has the right to, and the facility must promote and facilitate, resident, self-determination through support of resident choice, including but not limited to the rights specified in this section. A. each resident has right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care. B. Each resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>R18's MDS (Minimum Data Set) dated 4/21/2025 documents R18's BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating R18 is cognitively intact.</p> <p>On 5/21/25 at 12:11 PM R18 was in dining room on her hallway, had hands over her eyes and was crying. When asked what was wrong, she stated Is this some sort of punishment? I don't want to be up. I want to be in bed. I hurt, I am miserable, the light is directly in my eyes and every time I ask to go back to bed, they say they are going to go get help and then they do not come back.</p> <p>On 05/21/25 at 12:13 PM V16 (Certified Nurse Aid) stated that this resident never wants to get up, but the nurses say to get her up for at least every meal. V16 confirmed that R18 told her while she was getting her out of bed that R18 did not want to get up.</p> <p>On 05/21/25 12:13 PM V17 (Licensed Practical Nurse) stated (R18) does not want to get up, if we would let her she would just drink her chocolate shakes and eat those big chocolate bars she has in her freezer down there. (in her room). V17 confirmed that this resident is able to make her needs known and does make her own care decisions but maybe shouldn't, she doesn't take care of herself, she is diabetic, she needs food, not shakes and chocolate. She needs to be up and moving. V17 denied ever telling any staff member to get R18 out of bed when she did not wish to.</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 0561</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/22/25 at 11:02 AM V1 (Administrator) stated that no resident should be gotten up against their own wishes.</p> <p>On 5/22/25 at 11:03 AM V4 (Social Service Director) stated that R18 should not have been gotten out of bed if she did not want to. V4 confirmed that V16 (Certified Nurse Aid) came to her after she was questioned about getting R18 up. V4 stated I think (V16/CNA) thought she was doing the right thing, but I educated her that we do not get people up against their wishes ever.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970</p> <p>Based on record review and interview the facility failed to track specific behaviors for the use of an antipsychotic and failed to document any non pharmacological interventions used prior to psychotropic medication use for two residents (R24 and R32) of five residents reviewed for unnecessary medications in a total sample of fifty-seven.</p> <p>Findings Include:</p> <p>The Facility's Psychotropic Medication Management policy dated 11/1/2015 documents the purpose of the policy is to provide guidance for the psychopharmacological drug treatment for a resident with specific conditions, including but not limited to dementia and other cognitive disorders, and/or behaviors as documented in the resident's clinical record. The medical record documentation must reflect the specific behaviors/symptoms and the resident's response to non-pharmacological interventions to manage the behaviors/symptoms.</p> <p>The Facility's Psychotropic Medication Management policy also documents A plan of care will be developed to include precipitating factors, non-pharmacological interventions and potential side effects.</p> <p>R24's Physician Order Sheet for May 2025 documents that he takes the anti-anxiety medication Buspirone 10 mg twice a day for anxiety, the sedative/hypnotic medication Melatonin 5 mg every night for sleep aid, the antidepressant medication Sertraline 100 mg twice daily and the anti-psychotic medication Risperidone 0.25 mg every day for developmental disorder and unspecified psychosis and anxiety.</p> <p>R24's current care plan documents resident currently has an alteration in his behavior status related to fetal alcohol syndrome, intellectual disabilities. Urinating in windows, having bowel movements in inappropriate areas, restlessness, cussing, delusions, taking others belongings, hallucinations, psychosis, aggression, refusing cares, agitating staff and other residents. R24's care plan documents Interventions as Behaviors: Hallucinations; Behaviors: Hitting walls, slamming walker down; Behaviors: Negative Comments; Behavior: Physical Aggression; Behavior: taking items that are not mine; Behavior: Verbally aggressive/yells at staff during cares, Behaviors: Yells out/moans.</p> <p>R24's Medication Administration Record for May 2025 documents Behavior Monitoring: rejection of cares (Medications), (Activities of Daily Living), abs, meals, therapy. Document 14 for no behavior, document 15 for behavior. PN (Progress Note) interventions and outcome every shift.</p> <p>R25's Medication Administration Record for May 2025 either had a check mark or a 14 documented for every day.</p> <p>On 5/22/25 at 9:00 AM V1 (Administrator) stated she believes the check mark indicates that a behavior did occur.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R25's May MAR documents a check mark on: 5/1/25,5/2/25,5/5/25,5/6/25,5/9/25,5/10/25,5/11/25,5/12/25, 5/13/25,5/15/25,5/16/25,5/18/25,5/19/25,5/20/25,5/22/25,5/24/25,5/25/25,5/26/25,5/27/25,5/29/25 and 5/30/25.</p> <p>On 5/22/25 at 9:00 AM V1 (Administrator) confirmed that none of the check marks had corresponding progress notes to describe what behavior was occurring and what non pharmaceutical interventions were attempted and how the resident responded to the interventions. V1 also confirmed that the behaviors listed on the care plan are not the same.</p> <p>Throughout the survey R25 walked throughout the facility, was pleasantly confused and interacted with staff and other residents with no agitation or aggression noted.</p> <p>50962</p> <p>2. R32's Admission Record documents that R32's date of admission to the facility was 3/5/25 and his diagnoses on admission include Unspecified Dementia, Severe, with agitation, Anxiety Disorder, Depression, Hypertension, Altered Mental Status and Adult Failure to Thrive.</p> <p>R32's Minimum Data Set (MDS) dated [DATE] documents cognition as severely impaired and Section E documents physical behaviors, verbal behaviors, and behavioral symptoms directed toward others.</p> <p>R32's Physician Order dated 3/7/25 documents that R32 has an order for Quetiapine Fumarate/Seroquel (antipsychotic) 50mg (milligrams) by mouth twice a day for agitation related to Unspecified Dementia, Severe, with agitation and Ativan 1mg-Benadryl 25mg-Haldol 2mg (combination of antianxiety, antihistamine, antipsychotic) cream apply one milliliter (ml) topically every four hours as needed for aggression/anxiety.</p> <p>R32's current care plan documents R32 receives antipsychotic therapy and antianxiety therapy with no indication for use.</p> <p>R32's Medication Administration Records for March 2025, April 2025, and May 2025 documents behavior monitoring with behaviors occurring, but no specific behavior documented, or non-pharmacological interventions documented.</p> <p>R32's progress notes dated 3/6/25, 3/8/25, 3/9/25, 3/10/25, 3/16/25, 3/18/25, 3/19/25, 4/10/25 and 4/11/25 document combative and resistive behaviors with no attempted interventions during behaviors or prior to administering psychotropic medications.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>34542</p> <p>Based on observation, record review, and interview, the facility failed to update/revise Care Plans, to include contact precautions, for one resident (R48), of one resident, reviewed for Care Plan revisions, in a total sample of 57 residents.</p> <p>FINDINGS INCLUDE:</p> <p>Facility policy, entitled Comprehensive Care Plan, Revised 6/25/2024, documents, 3. Each resident's comprehensive care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care f. Aid in preventing or reducing declines in the resident's functional status and/ functional levels; and g. Enhance the optimal functioning of the resident by focusing on a rehabilitative program. 4. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment. 5. Care plans are revised as changes in the resident's condition dictate.</p> <p>On 5/20/2025, at 10:00 a.m., R48's room door was observed to be closed with contact isolation signs and a personal protective equipment/PPE cart by R48's door.</p> <p>On 5/20/2025, at 10:25 a.m., V1/Administrator confirmed R48 is on contact isolation precautions.</p> <p>R48's Electronic Medical Record/EMR document, Physician Order, dated 1/21/2025, Infection Precautions - contact Isolation: Resident is isolated in room, without a roommate or cohort with like pathogen, due to active infection with transmissible significant pathogens. Above standard transmission precautions maintained, with activities and all service brought to the resident.</p> <p>On 5/20/2025, at 1:00 p.m., V1 confirmed R48's Care Plan should have been revised to include R48's contact isolation precautions.</p>		

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970</p> <p>Based on interview and record review the facility failed to thoroughly document an instance of suicidal ideation and failed to monitor one resident after verbalization of suicidal ideation (R18) of five residents reviewed for mood and behavior in a total sample of fifty-seven.</p> <p>Findings Include:</p> <p>The Facility's Responding to Intent of Self-Harm policy dated 3/13/2023 documents the purpose of the policy is to establish a process to identify and respond to the risk of self-harmful thoughts, behaviors and action to ensure resident safety. Suicidal Ideation-verbal expressions of thoughts of harming oneself that may or may not lack specific intent or associated actions and which are generally vague, passing thoughts related to poorly defined, circumstantial issues.</p> <p>The Facility's Responding to Intent of Self-Harm policy documents any staff member who becomes aware of a resident's intent to inflict self-harm, including but not limited to suicidal ideation, suicidal attempt and/or parasuicidal behaviors/self-directed violence, is required to report that behavior to the Nursing Supervisor without delay. The charge nurse/Nurse Supervisor will immediately assess the situation to determine the presence of risk to the resident and what intervention if any, is needed.</p> <p>The Facility's Charting and Documentation policy dated 11/5/2023 documents its purpose is to maintain a medical record to serve a legal document that details the services provided to the resident or any changes in the resident's medical or mental condition, through charting and documentation. Documentation will include information assessment, notifications, interventions and evaluation including but not limited to a. incidents/accidents per facility policy b. change in condition per facility policy c. physician notification d. DPOA/Responsible Party notification e. Refusal of medications/treatment or recommendations f. education provided t resident and/or DPOA/responsible party g. status updates/summaries as required h. transfer, discharges and/or leave of absences. Additional documentation requirements will be followed: D. Alert charting-documentation of incident/accident or change in condition for 72 hours or until stable.</p> <p>R18's Medical Record documents she was admitted on [DATE] with diagnosis to include but not limited to metabolic encephalopathy, anxiety, and major depression disorder.</p> <p>R18's Nurse's Notes dated 4/30/25 at 4:30 PM document Resident sent to the hospital, suicidal.</p> <p>R18's Nurse's Notes do not include any physical assessment or behavior assessment. No vitals or indications of what R18 might have said to trigger being sent to the emergency room .</p> <p>(continued on next page)</p>		

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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>On 5/21/25 at 2:30 PM V1 (Administrator) stated (V9/Psychiatric Nurse Practitioner) sent (R18) in for a psych eval for suicidal statements. V1 could not state what R18 said or threatened to do or if R18 had a plan. V1 stated there would be no assessment documented by the nurse because we had a provider in the room who was giving an order to send her to the emergency room . V1 clarified that the psych nurse practitioner is a telehealth provider and would not be able to do a physical assessment. V1 stated they send someone nonclinical around with the iPad to talk to residents. In this case the non-clinical person who was holding the iPad for (V9) came out of the room and gave the iPad to a nurse to talk to (V9/Psychiatric Nurse Practitioner). The nurse then sent R18 to the emergency room . V1 still could not describe why R18 was going to the emergency room .</p> <p>On 5/22/25 at 958 AM V9 (Psych Nurse Practitioner) stated that she wanted R18 sent to the emergency room for a psych eval due to her stating that she didn't want to live anymore. V9 stated (R18) has no family and one close friend. She is very depressed. But she had no plan on how to commit suicide. She is just having a very hard time adjusting to being in a nursing home. I wanted to err on the side of caution and to demonstrate that we take these statements seriously. V9 stated that from her perspective via iPad that she could assess and did deem R18 not an immediate risk to herself. I just wanted to be super careful because she is so depressed.</p> <p>R18's Psychiatric Evaluation and consultation dated 4/30/2025 (no time listed) documents Made statements saying she wants to die by May 1st (tomorrow). Endorsing SI (Suicide Ideation) with no plan. States she doesn't want to live anymore or take her medications. States she misses her brother who passed away a month ago. She is grieving poorly.</p> <p>R18's Nurse's Notes dated 4/30/25 at 6:30 PM document Resident returned from the hospital, she was declared not suicidal.</p> <p>R18's Nurse's Notes do not include any physical assessment or behavior assessment. No vitals or indications of what R18 might have said to trigger being sent to the emergency room .</p> <p>R18's Medical Record does not contain any further documentation regarding R18's suicidal ideation on 4/30/25.</p> <p>R18's Care plan does not include any mention of suicidal ideation on 4/30/25 or any new interventions or increased monitoring for R18.</p> <p>On 5/21/25 at 11:30 AM R18 stated I know I said I wanted to die. I am not going to kill myself. I just miss my brother so much. I don't like being alone.</p> <p>On 5/22/25 at 1:00 PM V2 (Director of Nursing) stated there should have been follow up alert charting done on R18 after suicidal ideation on 4/30/25. The documentation in this case was very poor.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50962</p> <p>Facility failures resulted in two deficient practices.</p> <p>A. Based on observation, interview, and record review the facility failed to store medications in a secure environment for one (R57) of 15 residents whose rooms were assessed for cleanliness and safety in a sample of fifty seven. This failure has the potential to affect all 20 wandering residents (R3, R4, R5, R8, R11, R12, R13, R16, R22, R23, R28, R34, R36, R37, R41, R44, R45, R46, R51, R52) residing in the facility.</p> <p>B. Based on observation, interview and record review the facility failed to address confused residents (R11 and R28) entering a room of one resident (R49) and failed to investigate an report of an injury of one resident (R49) of fifteen residents reviewed for choices in a total sample of fifty-seven.</p> <p>Findings include:</p> <p>A.The facility's policy titled Storage, Labeling of OTC (Over the Counter) Medication, Destruction and Disposal of Medication, revised November 9, 2024, documents, To ensure that medications and biologicals are stored in a safe, secure storage and safe handling. Compartments containing medications should be locked when not in use. Trays or carts used to transport such items should not be left unattended. (Note: Compartments include, but are not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes). Medications will be stored in an orderly manner in cabinets, drawers, or carts. Each resident is assigned a cubicle or drawer to prevent the possibility of a drug for one resident being given to another.</p> <p>R57's Admission record documents that R57's date of admission to the facility was 4/2/25 and her diagnoses include Encounter for other Orthopedic Care, Displaced Intertrochanteric Fracture of Left Femur, and Iron Deficiency Anemia.</p> <p>R57's current care plan documents R57 has alteration to her Integumentary (skin) System due to pressure ulcer to coccyx and skin impairment to bilateral heels.</p> <p>R57's Physician Order dated 5/21/25 documents R57 coccyx wound care treatment for Alginate with AG (Silver), cleanse wound bed with normal saline (NS) or sterile water, loosely apply Dakins (mixture bleach and boric acid diluted in water/antimicrobial solution) soaked gauze wet to moist dressing and cover daily and as needed (PRN) every four hours for wound care.</p> <p>On 5/20/25 at 10:30am, a bottle of Dakins (antimicrobial) Full Strength solution and a 1.5-ounce tube of Therahoney (medical grade honey dressing) noted sitting on top of R57's counter just inside doorway of room.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/20/25 at 2:15pm, V6 (Licensed Practical Nurse/LPN) verified the bottle of Dakins Solution and tube of Therahoney remained in R57's room and V6 stated it should be in the locked treatment cart when not being used. V6 also stated, We have a lot of wanderers that like to go in other resident rooms, this (referring to Dakins Solution and Therahoney) should not be left in here.</p> <p>On 5/21/25 at 2:00pm V1 (Administrator) stated that medicated treatment supplies should not be kept in resident rooms when not performing an active treatment.</p> <p>33970</p> <p>Findings Include:</p> <p>B. On 05/20/25 at 10:30 AM R49 was lying in bed and talking on her cell phone. (R28/another wandering resident) entered resident room with shuffling gait and mumbling. R49 stated Hi (R28), this isn't your room, turn around. R49 kept talking on her phone. R28 continued into the room. R49 stated into the phone I am going to have to let you go, I have to get her out of here. R49 transferred herself to her wheelchair and put on slippers and said come on (R28), you walk in front of me. R28 grabbed R49's hand and was easily walked out the residents door and continued on down the hallway.</p> <p>On 5/20/25 at 10:35 AM R49 stated this happens all the time. (R28) doesn't really bother me because she will leave easily, she's just very confused. (R11) is the one who wanders in and won't get out. (R11) comes in and uses my bathroom gets the seat all gross, gets water everywhere when she is washing her hands, goes through my stuff and has tried to get into my bed with me. Just this morning around 6:30 AM (R11) slammed open my door and came in and started going through my stuff. They (staff) don't keep a good enough eye on either one of them, but I am scared of (R11), I am going home on Thursday because I can get more rest there when I am not chasing those two (R11 and R28) out of my room.</p> <p>R11's Physician Order Sheet for May 2025 documents diagnosis to include but not limited to Alzheimer's Disease.</p> <p>R11's current Care Plan documents resident current risk for Wandering/Elopement is high risk and her safety will be monitored every shift by staff.</p> <p>R11's MDS Minimum Data Set, dated dated dated [DATE] documents R11's BIMS (Brief Interview for Mental Status) score as 5 out of possible 15, indicating R11 is severely cognitively impaired.</p> <p>R11's MDS dated [DATE] documents that the behavior of wandering behavior of this type occurred daily.</p> <p>R28's Physician Order Sheet for May 2025 documents diagnosis to include but not limited to anxiety and dementia.</p> <p>R28's current Care Plan documents Resident's current risk for wandering/elopement is high risk 7 or higher and her safety will be monitored every shift by all staff.</p> <p>R28's MDS (Minimum Data Set) dated 5/2/25 documents R28 is rarely/never understood.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R28's MDS dated [DATE] documents that the behavior of wandering behavior of this type occurred daily.</p> <p>Throughout the survey R28 walked up and down all of the hallways in the facility and went in and out of resident rooms and offices.</p> <p>Throughout the survey R11 propelled her wheelchair up and down the three hallways on the side of the building that she lives on. R11 ran into stationary objects frequently and became irritated and readjusted and continued on down the hallway.</p> <p>R49's Nurse's Note dated 4/7/25 at 7:15 PM documents (R49) claimed, that she tried catch another resident and now she has sore in abdomen (right) and (left) upper quadrants, bruises not present, pain medication was administrated.</p> <p>On 5/22/25 at 8:52 AM R49 stated that the incident documented on 4/7/25 at 7:15 PM was about a time R11 came in R49's room and was trying to get past me but stubbed her toe on my wheelchair and fell on to me landing in my lap, I instinctively wrapped my arms around her to keep her from falling on the ground herself. I had a light purple bruise for a couple of days where her elbow or shoulder hit me and I was sore for a week. Even after that, they (facility) did not stop her from coming and going out of my room.</p> <p>R49's Medical Record does not contain any follow up documentation of the area on R49's abdomen from R11 landing in her lap.</p> <p>On 5/23/25 at 11:00 AM V1 (Administrator) could not provide any further information on any steps to take to prevent confused residents from entering R49's room. V1 could not provide any investigation into the documented incident of R11 falling into R49's lap.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2025
NAME OF PROVIDER OR SUPPLIER Lacon Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 401 9th Street Lacon, IL 61540	

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>34542</p> <p>Based on observation, interview, and record review, the facility failed to ensure the lids of trash dumpsters, located outside, are closed/secure to prohibit pests/animals from gaining access to discarded food/trash. This failure has the potential to effect all 57 residents residing in the facility.</p> <p>FINDINGS INCLUDE:</p> <p>Centers for Medicare and Medicaid Services [CMS] Form 671 [Long-term Care Facility Application for Medicare and Medicaid], dated 5/20/25, signed by V1/Administrator, document 57 residents reside in the facility.</p> <p>Facility policy, entitled Food Related Garbage & Rubbish Disposal, Revised 12/30/2024, document, 2. All garbage and rubbish containers shall be provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use; 5. Garbage and rubbish containing feed wastes will be stored in a manner that is inaccessible to vermin.</p> <p>On 5/20/2025, at 9:10 a.m., during the initial kitchen tour, with V19/Dietary Manager, the lids of the trash dumpster, located outside, were missing two lids and trash was piled above the top of the trash dumpster. The large, steel, trash dumpster, is not secured by any walls/access doors.</p> <p>On 5/20/2025, at 9:10 a.m., V19 confirmed, the trash dumpster was missing two lids and the dumpster should be kept closed/secured in order to prohibit access by pests/animals.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33970</p> <p>Facility failures resulted in two deficient practices.</p> <p>A. Based on observation, record review and interview the facility, the facility failed to wear appropriate Personal Protective Equipment/PPE in a transmission-based precautions room and failed to perform hand hygiene after exiting the room. This failure has the potential to affect all residents whose medications were stored in the medication cart (R9, R18, R22, R25, R31, R35, R36, R39, R40, R47, R49, R50, R111). The facility also failed to follow its policy for Isolation Precautions for two of two residents (R18, R40) reviewed for Contact Precautions in the sample of 57.</p> <p>B. Based on observation, interview and record review the facility failed to perform hand hygiene between glove changes for one of one residents (R57) reviewed for wound care in a sample of 57.</p> <p>Findings include:</p> <p>A. The Facility's Isolation Precautions policy dated 8/20/2020 documents the policy is to establish transmission-based precautions for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others.</p> <p>The Facility's Isolation Precautions policy documents Contact Precautions: 1. Implemented for residents suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces/equipment in the resident's environment. Prior to entering the isolation room, the following steps are required: a. perform hand-hygiene and apply gloves and gown prior to entering room; b. While providing direct resident care, wear gloves and wash hands after coming in contact with infectious material; c. remove gloves and perform hand-hygiene before leaving room (do not use alcohol-based hand gels for isolation due to suspected or confirmed Clostridium difficile); d. adequately clean/disinfect an item with an approved solution prior to removing the item from there room and before use on another resident.</p> <p>R18's Physician Order Sheet dated May 2025 documents Contact Precautions for ESBL (Extended-Spectrum Beta Lactamases) in the urine.</p> <p>R18's MDS (Minimum Data Set) dated 4/16/25 documents R18 is always incontinent of urine. R18's MDS documents that she is dependent on staff for incontinent cares.</p> <p>R18's door had 2 sheets of paper taped to it. The papers documented R18 was in contact precautions. R18's contact precaution sign on the door indicated to perform hand hygiene and don gloves and gown before entering the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/22/25 at 11:12 AM V18 (Licensed Practical Nurse) went up to the sign and stated I am just going to be real with you, I do not usually put on all the PPE (Personal Protective Equipment) when I go in R18's room to give her insulin because I do not touch anything other than her arm. V18 donned gloves without performing hand hygiene and entered R18's room. R18 was drowsy and mumbling. V18 touched her shoulder, shaking her saying Wake up, I have your insulin. R18 stated I need my purse; I was just putting everything in it. No purse could be obviously seen. V18 leaned over R18, causing the entire front of her scrub top and the top of her scrub pants to be touch R18 and/or her bed. V18 pulled the covers back and ran her hands up and down R18's body to demonstrate to R18 that her purse was not in the bed. V18 opened closets, drawers and went in the bathroom. V18 told R18 that she would give her insulin and then go check her old room for her purse. V18 administered the insulin and left R18's room with insulin pen still in her gloved hand. V18 returned to the medication cart in the hallway and opened drawers and removed the needle off the insulin pen and put it back in the cart with the other insulin pens. R18 then removed her gloves and threw them away but still did not perform hand hygiene in any manner.</p> <p>On 5/22/25 at 2:00 PM V18 confirmed she should have put a gown on prior to entering R18's room. V18 reported that the following residents have their medications stored in the same medication cart: (R9, R18, R22, R25, R31, R35, R36, R39, R40, R47, R49, R50, R111).</p> <p>On 5/22/25 at 2:30 PM V1 (Administrator/Infection Preventionist) stated that all staff should wear the designated PPE in all transmission-based precautions rooms every time they enter.</p> <p>38805</p> <p>2. Documentation and staff interviews indicated that R18 has Extended-Spectrum Beta-Lactamases/ESBL of urine; and R40 has Vancomycin-Resistant Enterococcus/VRE bacteria in urine. Signage posted on R18 and R40's doors documents Contact Precautions.</p> <p>(5/22/25 Internet definitions: ESBL: Makes some antibiotics ineffective in treating bacterial infections. ESBLs break down certain antibiotics, making some infections caused by ESBL-producing Enterobacterales difficult to treat. VRE: It is an infection with bacteria that are resistant to the antibiotic called Vancomycin.)</p> <p>On 5/21/25 at 9:45am, V12 Speech Therapist was noted in R40's room and was not wearing an isolation gown. V12 stated that she had speech therapy with R40's roommate (R47). V12 stated, I only wear gloves when I go in to see (R47); was not aware I was supposed to wear a gown. At this same time, V12 stated that she was not supposed to wear a gown because she was not doing patient care with R40; and stated that R47 was not on isolation.</p> <p>On 5/21/25 at 9:50am, V11 Housekeeping was noted doing housekeeping chores on R18 and R40's Unit. V11 stated that when she goes in resident contact isolation rooms, that usually she wears only gloves and stated that Administration staff may have educated her on wearing full PPE (Personal Protective Equipment), she does this sometimes, but usually just wears gloves. V11 stated, It depends on how rushed I am feeling, sometimes I put on all the PPE and gloves.</p> <p>On 5/21/25 at 9:57am, V3 Assistant Director of Nursing/ADON stated that PPE, gloves and gowns, should be worn by all staff when going into rooms of residents who were on contact precautions, and this included Housekeeping and Therapy staff.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50962</p> <p>B. The facility's policy titled Hand Hygiene, reviewed/ revised 4/24/24, documents, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.</p> <p>R57's Admission record documents that R57's date of admission to the facility was 4/2/25 and her diagnoses include Encounter for other Orthopedic Care, Displaced Intertrochanteric Fracture of Left Femur, and Iron Deficiency Anemia.</p> <p>R57's current care plan documents R57 has alteration to her Integumentary (skin) System due to pressure ulcer to coccyx and skin impairment to bilateral heels.</p> <p>R57's Physician Order dated 5/21/25 documents R57's left heel wound care treatment as left heel cover with bordered gauze as needed to protect from friction every Tuesday, Thursday, Saturday and right heel order dated 5/13/25 as apply barrier wipe daily and as needed.</p> <p>R57's current care plan documents R57 has an alteration to her Integumentary (skin) System due to pressure ulcer to coccyx and skin impairment to bilateral heels.</p> <p>05/22/25 11:45 AM V2 (Director of Nursing/DON) noted to do hand hygiene, don gown and gloves and enter R57's room to perform treatment on bilateral heels. Once in room V2 obtained permission from R57 to do wound care and R57 agreed. V2 removed R57's heel boot to left foot, removed sock and opened up barrier wipe, wiped left heel wound, removed gloves and placed new gloves without doing hand hygiene, then opened dressing of bordered gauze and placed to left heel wound. V2 then removed gloves, placed new gloves without performing hand hygiene, removed R57's right heel boot and sock, then opened barrier wipe, wiped right heel wound and replaced sock and boot. V2 verified that she did not perform hand hygiene between glove changes and stated she should have.</p>		