STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005490	A. BUILDING: _____ B. WING _____	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN VILLAGE HEALTHCARE	2202 NORTH KICKAPOO STREET LINCOLN, IL 62656

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2220998/IL143238 Facility Report Incident of 1-28-22/IL143469	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility neglected to follow their Resident Rights Protocol and Answering the Call Light policy for one of four residents (R2) reviewed for abuse/neglect and resident rights in the sample of eight. This neglect resulted in R2 exhibiting sustained and intense crying, moaning, and yelling. Findings include: The facility's Resident Rights Protocol for All	S9999		

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S9999	Continued From page 2 Nursing Procedures (revised August 2008) document resident rights including "1.b. Resident dignity and respect," "1.f. Resident right of refusal," and "1.h. Resident freedom of choice." The facility's Answering the Call Light policy (revised August 2008) documents the following: "3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system," "5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident," and "6. Some residents may not be able to use their call light. Be sure to check these residents frequently." R2's face sheet and admission record documents he was admitted to the facility on 5/18/21 to the Respiratory unit for treatment and care required for tracheostomy and ventilator dependence. R2's progress notes and census sheet document he was moved from the Respiratory unit to a general care room on 1/14/22 due to weaning off the ventilator. R2's medical records document diagnoses of Chronic respiratory failure with hypoxia, COVID 19, Seizures, Malnutrition, Anxiety, Dysphagia, Contractures, Gastrostomy, Diffuse traumatic brain injury with loss of consciousness, and Expressive language disorder. R2's Minimum Data Set (MDS) assessment dated 1/3/22 documents R2's speech is not clear, he sometimes understands and is sometimes understood, is moderately cognitively impaired, totally dependent on staff for all Activities of Daily Living (ADL), receives enteral feedings, and has bilateral impairment of upper and lower extremities. R2's current Care Plan documents the following:	S9999		

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S9999	Continued From page 3 Include resident's preference in rendering care and services, (R2) total dependence on staff for all ADL, encourage to use bell to call for assistance, call light within his reach when in room, monitor and record any nonverbal signs of pain (crying, moaning), monitor for psychosocial changes, observe and report any changes in mental status caused by situational stressor, and provide support for expression of feelings related to situational stressor. R2's Care Plan does not document any behaviors or any transmission-based precautions to be observed. On 2/8/22 at 9:30am, R2 was lying in his bed on his back. R2 had contractures of his upper extremities with his fists drawn tightly up to his shoulders and his lower extremities with heels drawn up near buttocks, requiring padding to prevent pressure on this area. R2 was unable to form words but was able to moan and nod 'yes' and 'no' and look to the right and left to indicate things in his room (example- where his letter board was mounted on the wall above the head of his bed). There was no call light within R2's reach. At 11:00am, 1:30pm, and 2:00pm, R2's door was closed, he was yelling, and no staff were in his room. There were no transmission-based precautions in place for R2. On 2/9/22 from 8:30am-9:00am, and 9:30am, R2's door was closed and R2 was yelling and crying. There were no staff present in R2's room. Upon entering R2's room at 9:30am, R2 was sobbing/crying, face red, trying to talk/mouth moving but unable to speak, his face was covered with tears, he was shaking. and moving his head back and forth. R2 indicated to V9 (Certified Nursing Assistant/CNA) that his "butt hurt." At this time, R2 was asked if he wanted his door closed and he shook his head "no" back and	S9999		

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S9999	Continued From page 4	S9999		

forth repeatedly. R2 nodded "yes" repeatedly when asked if he wanted his door kept open. There was no call light or alternative call light within resident reach at this time.

On 2/9/22 at 9:00am, V9 (CNA) stated, "(R2) screams all day. We keep his door closed so the other residents aren't bothered. He yells all day." When asked how R2 alerts staff when he needs something or is in pain, V9 shrugged.

On 2/9/22 at 9:40am, V5 (Licensed Practical Nurse/LPN)/Wound Nurse) stated staff should not close R2's door because R2 cannot use a touch pad call light for assistance due to his contractures.

On 2/10/22 at 8:15am, V3 (Director of Nursing/DON) stated and confirmed that the only call light in R2's room was a push button call light which R2 was unable to use, which was over the head of the bed and on the floor, and not within R2's reach. V3 stated staff should not be keeping R2's door closed because of his yelling. V3 stated R2 was used to receiving more socialization/interaction from the increased number of staff in the Respiratory unit which he does not receive on the general unit, and R2's yelling is a behavior.

On 2/8/22 at 2:13pm, V12 (R2's family member) stated facility staff do not let R2 keep his door open because they do not want to hear when he needs help.

" B"