STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145256	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Rehab & Healthcare Center	800 West Temple Street Effingham, IL 62401

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36384 Based on interview and record review, the facility failed to ensure residents are free from abuse for two of three residents (R2 and R6) reviewed for abuse in the sample of 3. This failure resulted in R6 experiencing having clothing placed over his mouth twice in an attempt to quiet him. A reasonable person would also experience feelings of humiliation, intimidation, fear, emotional distress, and helplessness as a result. This past non-compliance occurred between 4/13/24 and 4/16/24. Findings include: 1.R6's face Sheet documented an admitted [DATE], and diagnoses including Autistic Disorder, Dysphagia, Repeated Falls, and Unspecified Intellectual Disabilities. R6's Minimum Data Set (MDS) dated for 3/12/2024, documents that R6 has a Brief Interview for Mental Status (BIMS) score of 3, indicating that R6 has severe cognitive impairment. The same MDS documents that R6 is totally dependent on at least two persons assist for upper and lower body dressing. On 5/10/2024 at 1:40pm, attempted interview with R6 but due to severe cognitive impairment, R6 was unable to answer questions appropriately. On 5/10/2024 at 10:26am, V1 (Administrator) stated she was notified on 4/13/2024 at approximately 9:00am by V21 (Licensed Practical Nurse/ LPN) about an allegation of abuse. The allegation of abuse involved staff V23 (Certified Nurse's Assistant/ CNA) to R6. V1 stated V21 reported the allegation of abuse to her and that V23 was escorted out of the facility and R6 was assessed. V1 stated that R6 is unable to recall the event due to his diagnoses and appears to be doing well. V1 stated that V23's employment was terminated due to substantiated abuse allegation. V1 stated that it was reported to her by V21 that V12 (Certified Nurse Assistant/CNA) witnessed an abuse situation between V23 and R6. V1 stated that R6 has verbal outbursts regularly due to his diagnosis and V23 covered his mouth with clothing two different times while getting him ready for supper. V1 stated that she has never had any issues with V23 having abused any residents before, and was surprised and saddened that this was reported. V1 stated that V21 had V23 leave the facility as soon as this was reported. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/10/24 at 11:07AM, V12 (CNA) stated that on 4/13/24 she and V23 were assisting R6 in getting ready for supper. V12 stated that R6 was not acting different that his normal state of yelling out. V12 states that R6 at times yells and is not having any distress or pain but is just part of his verbal outbursts associated with autism. V12 stated that as she and V23 were assisting R6 with getting dressed, V23 placed his pants and shirt at two different times over his mouth to quiet him while saying when you stop, I'll stop. V23 stated that R6 was not acting any different than normal behavior and was not harming himself or anyone. V12 feels that emotionally R6 is doing better now that V23 no longer works here. V12 stated that R6 is unable to communicate how he feels or what happened that day due to his speech impairments, but he appears to be doing well. On 5/10/24 at 11:37AM, V21 stated that V12 came and reported the incident of abuse to her as soon as it happened. V21 stated that she immediately checked on R6 and he was eating dinner and appeared to be doing well and could not recall the situation. V21 stated that she then had V23 write a statement of what occurred and was walked out of the building and she reported the incident to V1 who is the abuse coordinator. On 5/14/24 at 11:15AM, V24 (Family Member) stated that the facility reported to him on the day that the abuse occurred and told him the employee was terminated. V24 has no concerns with the facility and feels they take great care of R6. The Abuse Investigation provided by the facility was reviewed regarding the incident between V23 and R6. A typed statement dated 4/13/24 from V21 documents the following: On 4/13/24, I was assigned as floor nurse on 200 hall. I started work at 1530 (3:30PM). Began passing meds (medications) around 1600 (4:00 PM). Around 1615 (4:15 PM) V12 approached me at the med (medication) cart and stated I need to tell you something about V23 when we get to the dining room. I stated okay and passed the medication. V12 stated that while V23 and I were getting R6 up for dinner, he was screaming and V23 held his shirt over his mouth and said, 'you stop and I'll stop. Then we got R6 transferred into his wheelchair, he began screaming again and V23 took R6's pants and again put it over his mouth and stated, you stop and I'll stop. I (V21) immediately locked my medication cart and went to find V23 and asked her to speak with me. V23 admitted that she did indeed hold his shirt, and then his pants over his mouth in an effort to get him to stop screaming, and then stated, well it wasn't covering his nose. I (V21) replied in question do we cover our resident's mouths in order to quiet or console them? She (V23) replied well, I have before. I (V21) questioned her stating do you understand this is abuse and you legally cannot do that? she (V23) stated she hadn't done it at this facility before today. I (V21) replied we are going to have to ask you to clock out and leave the facility, I am required to report this to V1, our administrator and she will be in contact with you if she needs anything further. She (V23) stated I will call V1 myself. I (V21) stated that is fine, but I am still required to contact her myself. V23 left the facility with no issues. 2. R2's admission record documents an admitted [DATE]. This same document has a date of birth as 6/25/33 and includes the following diagnoses: Acute Respiratory Failure, Major Depressive Disorder, and vascular dementia. R2's 4/4/24 MDS Section C documents a BIMS of 3 indicating a cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/7/24 at 1:05PM, V10 (CNA) stated that she was working the day the incident occurred when R5 wandered into R2's room. When R2 told him to leave he mumbled something and shoved R2 which caused her to stumble and fall hitting her back on the bed. V10 stated that she witnessed R2 stumble and fall on her bottom but did not hit her head. V10 went on to state that R2 does not remember the incident and has not had any behavioral concerns resulting from this happening to her, nor has she had any lasting effects. V10 stated that she was assessed immediately. Nursing progress note from 5/3/2024 by V29 (LPN) documents R5 entered R2's room and R2 stood up and told R5 to get out and R5 shoved her in the chest causing R2 to fall. R2 landed on her bottom. R2 hit her mid back on the side rail of the bed but did not hit her head. V29 notified POA (Power of Attorney) and physician. No new orders at this time due to no injury noted. On 5/7/24 at 10:26 AM, V1 stated that she substantiated the resident-to-resident abuse between R5 to R2. V1 stated that the police, the emergency contact and the physician were all notified and that R2 did not sustain any injuries from the physical abuse. V1 stated that R5 has had behaviors resulting in her initiating an involuntary discharge in January but could not find a facility that would accept him. V1 stated that after some medication changes his behaviors had slightly diminished so he was allowed to stay longer than expected, but after this incident he was sent to the local emergency room and not allowed to return. On 5/7/24 at 10:32AM, V25 (Family Member) stated that she was notified that R2 had a fall and that a resident had pushed her (R2) down in her room. V25 stated that she did not sustain any physical injury from this incident but is concerned that R5 would come back to the facility. V25 stated that she had not seen him since the call where she was informed, he wouldn't be returning, but she wanted to make sure. V25 stated that she felt he was unsafe to be around these elderly confused residents and is worried for her aunt and all the other resident's safety. On 5/7/24 at 1:30PM, R2 was attempted to be interviewed regarding the incident. However, due to cognitive impairment R2 was unable to answer questions appropriately. The facility policy titled Abuse Prevention and Prohibition Policy, with a revision date 11/24, documents under the statement of intent, Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Prior to the survey date, the facility took the following actions to correct the deficient practice: 1. A Quality Assurance and Performance Improvement meeting was held on 4/16/24. In attendance - V1, V8 (Director of Nursing), V17 (CNA), V2 (RN/MDSC - Minimum Data Set Coordinator/Care Plan Coordinator), and V18 (LPN), V27 (Physician). 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents have the potential to be affected. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V1 was educated on the abuse and neglect policy , resident rights by the regional nurse on 4/16/24. All residents were asked if they had any issues with staff abuse and all staff were educated on the abuse and neglect policy, resident rights by V1 on 4/16/24. 4. Plan to monitor performance to ensure solutions are sustained: V1 or designee will question 5 staff weekly for the next 60 days on the abuse policy to monitor for understanding. V1 or designee will question 5 residents weekly for the next 60 days to monitor for instances of abuse towards them.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36384 Based on interview and record review the facility failed to notify the resident in writing of the reason for transfer/discharge for 1 of 1 (R5) residents reviewed for transfer/discharges in the sample of 7. Findings Include: R5's Admission Record with a print date of 5/7/24 documents R5 was admitted to the facility on [DATE] with diagnoses that include Wernicke's encephalopathy, dementia, alcohol dependence with alcohol induced dementia, anxiety, insomnia, other seizures, and alcohol abuse with unspecified alcohol induced disorder. R5's Minimum Data Set (MDS) dated [DATE] documents in Section C that Cognitive skills for daily decision making are severely impaired. A Brief Interview of Mental Status was unable to be completed due to R5 rarely/never understood. R5's MDS (Minimum Data Set) dated 2/26/24 documents under Section GG, R1 is independent for all functional abilities, except he requires supervision for tub/shower transfer. R5's Care Plan with an admitted [DATE] documents a focus area of R5 has impaired cognitive function/dementia or impaired thought process. The interventions listed for this focus area are as follows: break tasks into small sub tasks to support short term memory deficits. Communicate with R5/family/caregivers regarding residents capabilities and needs. Used preferred name and identify yourself at each interaction. Face R5 when speaking and make eye contact. Reduce any distractions, turn off TV, radio, close door, etc. R5 understands, consistent, simple and directive sentences. Provide R5 with the necessary cues-stop and return if agitated. Engage R5 in simple, structured activities that avoid overly demanding tasks. Keep R5's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. R5 wanders in other residents rooms but does not interact with other residents. Nursing progress note from 5/3/2024 by V29 (Licensed Practical Nurse/LPN) documents R5 entered R2's room and R2 stood up and told R5 to get out and R5 shoved her in the chest causing R2 to fall. R2 landed on her bottom. R2 hit her mid back on the side rail of the bed but did not hit her head. V29 notified POA (Power of Attorney) and physician. No new orders at this time due to no injury noted. On 5/7/24 at 1:05PM, V10 (CNA) stated that she was working the day the incident occurred when R5 wandered into R2's room. When R2 told him to leave he mumbled something and shoved R2 which caused her to stumble and fall hitting her back on the bed. V10 stated that she witnessed R2 stumble and fall on her bottom but did not hit her head. V10 went on to state that R2 does not remember the incident and has not had any behavioral concerns resulting from this happening to her, nor has she had any lasting effects. V10 stated that she was assessed immediately. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 12:30 PM, V26 (Registered Nurse/RN) stated on the morning of 5/4/24 R5 took his morning medications with no problems and was asked to go to the dining room for breakfast. V27 stated that he began pacing the dining room and kept wandering into R2's room. V27 stated that he had to be redirected 3 times within 15 minutes and got very angry with her resulting in him cursing her and using the middle finger at her. V27 stated that she was in R2's room assisting her with the door closed and he punched the door attempting to get in the room. V27 stated that he then went out to the dining room and reared his fist back at a male resident but staff intervened prior to R5 hitting anyone or anything with his fist. V27 stated that she called V27 (Physician) and was directed to send to the emergency room for behaviors. V27 stated that she then called the family member and let her know R5 was being sent to the ER and would be discharged from the facility. V27 stated that she let the nurse know in the emergency room as well that R5 would not be allowed to return. V27 provided the hospital with V1's contact information should they have any further questions. On 5/10/24, at 10:00 AM, V1 (Administrator) stated that R5's involuntary discharge is not new, as it was originally initiated in January. V1 stated that placement had been attempted to several places and no one had accepted him. V1 stated that V6 (Family Member) was notified of the discharge being initiated on 1/12/24 and was OK with it. V1 stated that they had kept him longer than the 30 days post initiation of the involuntary discharge being filed due to his behaviors being slightly improved and he had gone to a local psychiatric unit and appeared that his behaviors were improved. V1 stated that they and tried several medication changes and the psychiatric nurse practitioner was very involved in his care, however when this event happened with R2 it was a safety issue for the residents if he remained in the facility. V1 stated that the hospital was notified that he would not be returning when they gave report and his wife was called and notified. V1 stated that she did not fill out any emergency discharge paperwork because she wasn't aware that she needed to and thought the January paperwork was enough. On 5/7/24 at 1:00 PM, V6 stated that the facility notified her in January that they would be discharging R5, but did not this time. V6 stated that R5 had been to a Psychiatric Hospital and came back to the facility and she assumed he was better because she had not heard anything else from the facility. V6 then stated that the nurse called her on 5/1/24 and said that he was sent to the hospital and would not be allowed to return. V6 stated that he is now accepted to a psychiatric facility out of state and that is where he will be going from the hospital. R5's progress notes entry documents on 5/4/24 at 15:59 (3:59PM) that V30 (Registered Nurse) phone facility requesting paperwork. Faxed face sheet/demographics, current orders/medication list and POLST (Physician Orders for Life Sustaining Treatment), V1 phone number given to V30 (Registered Nurse/RN-Hospital). R5's progress notes entry documents on 5/4/24 at 15:20 (3:20 PM) Resident left facility wearing blue jeans, red hoodie, socks, undergarments, shoes with his cell phone in his pocket. R5's progress notes entry documents on 5/4/24 at 15:20 (3:20 PM) that at 1450 (2:50 PM) that V27 (Medical Doctor) was phoned. At 1454 (2:54 PM) 911 dispatched, at 1455 (2:55 PM) report given to emergency room , at 1456 (2:56 PM) V6 was notified, at 1500 (3:00 PM) police officers x4 directed R5 off the unit due to safety concerns of other residents, at 1520 (3:20 PM) emergency room was phone to ensure R5 arrived and was then notified the facility will not be accepting R5 back here. Was served involuntary discharge papers prior to this happening. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 10:00 AM, V30 (Registered Nurse/RN-Hospital) stated that he called to the facility to confirm they would not be taking R5 back and that was confirmed by V1 (Administrator). V30 stated R5 is now being discharged to an out of state psychiatric facility for further care to manage his diagnosis. The facility's undated Resident Involuntary Discharge policy documents in part, It is the policy of the facility to only initiate involuntary discharge proceedings when the below listed situations exist. The facility's primary concern is for the health and safety of the affected resident and for the health and safety of the other residents, visitors, and staff members Resident notification. Prior to discharge, the resident and family members, surrogate or legal representative must be notified of the reasons for discharge. All conversations regarding potential discharge will be documented in the resident record Written notice must be provided at least 30 days in advance and include the following: the reason for discharge, the effective date of discharge, the resident's right to appeal the discharge with the State, and the telephone number and address of the appropriate office .The 30 day advance notice is not required under the following circumstances: When the resident is an endangerment to the health or safety of others in the facility. In the above cases notice must be provided as soon as is practicable before the transfer, but must be given before the resident leaves the facility. The notice will contain the same information as is given in the 30 day notice. The notice must also be provided to the resident's guardian or family member or durable power of attorney prior to discharge. In addition advise the facility receiving the resident, that you have discharged the resident and will not be accepting him/her back to your facility.