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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145256 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/11/2024 |
| NAME OF PROVIDER OR SUPPLIER Lakeland Rehab & Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on interview and record review, the facility failed to provide daily denture/oral hygiene care for 4 of 4 residents (R1, R7, R5, R6) reviewed for ADL (Activities of Daily Living) care in the sample of eleven.</p> <p>Findings include:</p> <p>1. R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Congestive Heart Failure, Anxiety Disorder, and Chronic Kidney Disease. R1's 1/5/24 Minimum Data Set (MDS) documented that R1 had severe deficits in cognitive function and required moderate assistance from staff for oral hygiene and denture care .</p> <p>On 6/4/24 at 8:20am, V4, Family Member of R1, stated she had noted on several occasions that R1's dentures were yellow, odorous, and covered with layers of caked on food particles.</p> <p>2. R7's Face Sheet documented an admitted [DATE] and listed diagnoses including Multiple Sclerosis and Diabetes Type 2. R7's 3/2/24 MDS documented that R6 had minimal deficits in cognitive functioning, had range of motion impairment to both upper extremities, and requires set up and clean up assistance for oral hygiene and denture care.</p> <p>On 6/5/24 at 9:40am, R7 was alert and oriented. R7 stated staff do not offer to help or remind her to clean her dentures. R7 stated staff will help her to clean them only if she asks, and, Some (staff) are more willing than others.</p> <p>3. R5's Face Sheet documented an admitted [DATE] and listed diagnoses including Diabetes Type 2 and history of Cerebral Infarction. R5's 4/18/24 MDS documented that R5 had minimal deficits in cognitive functioning, and that R5 requires set up and clean up assistance for oral hygiene and denture care.</p> <p>On 6/5/24 at 10:10am, R5 was alert and oriented. R5 stated she took out her top dentures and put them on the bedside table 2 weeks ago and hasn't seen them since, despite staff searching for them. R5 stated she has a dental appointment later this week to get impressions made for a new set. R5 stated she has some of her own teeth on the bottom. R5 stated the only time staff assist her with denture and oral care is when they have CNA (Certified Nursing Assistant) students working. R5 stated CNA staff are usually too busy to assist with denture care.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>4. R6's Face Sheet documented an admitted [DATE] and listed diagnoses including Atrial Fibrillation, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease. R6's 5/6/24 MDS documented that R6 had severe deficits in cognitive functioning, had restricted range of motion in both upper extremities, and that R6 required set up and clean up assistance for oral hygiene and denture care. A Grievance Form dated 5/12/24 completed by V5, Power of Attorney for R6, documents I am still not seeing workers posting on (R6's) calendar when they are brushing her teeth.</p> <p>On 6/6/24 at 12:45pm, V5 stated R6 has memory problems as well as a torn right rotator cuff and cannot lift her arm to do her own denture care. V5 stated when she took R6 to the dentist shortly after her May 2022 admission to the facility, the dentist showed her R6's top partial denture plate, Which was caked with layer upon layer of old food. He said she needed to have her teeth and dentures cleaned at least once daily. They (staff) weren't doing it so finally I put a calendar in her room and asked the CNA's to initial it whenever they did her oral care. I haven't put the June (2024) one up, there is probably no point, because nobody is initialing the calendar. I guess it's possible they're doing it but forgetting to mark it down. Whenever I ask the CNA's about why they're not doing it, whichever shift I'm talking to blames another shift. I did a grievance with the Administrator about it about mid May 2024.</p> <p>On 6/6/24 at 1:10pm, a large May 2024 calendar was observed in R6's room, which had been initialed on 5/2/24, 5/13/24, 5/16/24, and 5/20/24.</p> <p>On 6/6/24 at 1:20pm, V1, Administrator, confirmed V5 filed a grievance on 5/12/24 stating that CNA's were not taking care of R6's dentures and teeth, and that V5 had put a calendar in R6's room to initial when they performed oral care. V1 stated she believes staff are doing the oral care but not initialing it on the calendar. V1 stated there is nowhere in the electronic medical records to document when oral/denture care is done.</p> <p>On 6/5/25 at 2:20pm, V13, CNA, stated CNA's are to take out the dentures at bedtime, brush them, and soak them overnight with a cleaning tablet. V13 stated there have been occasions during morning care when he has noted that residents dentures have not been cleaned and soaked overnight.</p> <p>On 6/6/24 at 11:50am, V12, CNA, stated at bedtime, dentures are to be removed, cleaned, and soaked overnight. V12 stated dentures and teeth should also be brushed after meals.</p> <p>On 6/11/24 at 10:00am, V1 stated the facility does not have a denture care/oral hygiene policy.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - 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** 32619</p> <p>Based on interview and record review, the facility failed to remove surgical staples and to obtain an x-ray as ordered for 1 of 11 residents (R1) reviewed for quality of care in the sample of eleven. This failure resulted in R1's surgical hip incision becoming infected and requiring antibiotic therapy.</p> <p>Findings include:</p> <p>R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Congestive Heart Failure, Anxiety Disorder, and Chronic Kidney Disease. R1's 1/5/24 Minimum Data Set (MDS) documented that R1 had severe deficits in cognitive function.</p> <p>R1's Nursing Progress Notes documented the following:</p> <p>On 1/29/24 at 8:10am: Continues to complain of severe pain right hip/right leg. Had hydrocodone and ativan around 3:20am, then Tylenol at 7:12am. No relief. Moaning. Will not sit up in wheelchair straight. Total assist with toileting and transfer this morning, unable to stand on right leg. No internal/external rotation of extremities noted. Complains of pain when right leg or hip touched or when right leg is moved. Called (V14, Physician) office and notified of severe pain and no relief from pain medications. Asked for Xrays. New order received to send patient to ER (emergency room) for evaluation for severe right hip pain.</p> <p>On 1/29/23 at 11:37am: Called (local hospital) ER to check on patient, daughter at ER. Patient has Right hip fracture and will be admitted .</p> <p>On 2/5/24 at 4:38pm: (R1) was (re)admitted to our community.</p> <p>A 2/5/24 Hospital After Visit Summary documented, Reason for admission: Hip fracture due to Osteoporosis. Discharge instructions: Schedule an appointment with (V15, Orthopedic Surgeon) as soon as possible for a visit. Remove (surgical) staples (to right hip incision) on 2/8/24. X-ray hip 2/8/24. Does not have to come to the office unless there are problems, as needed. Keep dressing in place for seven days.</p> <p>R1's February 2024 Treatment Administration Record (TAR) documented, 2/5/24: Keep (right hip) dressing in place for seven days, (check) every shift. The TAR documented that this was done on all three shifts from 2/5/24 through 2/16/24. The same TAR documented, 2/5/24: On 2/8/24: Remove staples to right hip. There were no initials documented on the TAR on 2/8/24, indicating the staples had not been removed as ordered.</p> <p>R1's Nursing Progress Notes further documented the following:</p> <p>On 2/9/24 at 2:02pm: (Portable Xray Provider) Technician called stated he is so sick and cannot come to do her follow up x-ray, will come tomorrow.</p> <p>(continued on next page)</p> |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 2/10/24 at 5:00pm: Called (x-ray provider) (to) follow up x-ray ordered was not done yet. Reminded them (facility) called to set this up early in week. (Provider) reports no technicians to send out right now, they will send one out when they get someone.</p> <p>On 2/11/24 at 9:15pm: (Portable x-ray provider) was here to do follow-up x-ray of residents fractured right hip.</p> <p>There was no documentation in these notes to indicate V15 (Orthopedic Surgeon) had been notified that the x-ray was not able to be obtained per V15's order.</p> <p>R1's Progress Notes further document the following:</p> <p>On 2/12/24 at 9:33am: X-ray (right) hip done yesterday. Results came in last night. Sent report to (V15) for review. X-ray noted a total right hip replacement intact. Surrounding soft tissues normal.</p> <p>On 2/16/24 at 2:15pm: Right hip: Possible infection: Incision is red, warm to touch, has purulent drainage and a little swollen. Noted 24 staples. Called (V15's) office and spoke to his nurse (V6, Registered Nurse). (V6) said that she will call (V15) because he is on vacation and will get back to us.</p> <p>On 2/16/2024 at 2:38pm: (V6) called and she said that (V15) would like us to remove the staples and if we can take pictures to send. (V6) was advised that we are not allowed to take pictures. (V6) then stated if she can come over to take the pictures herself, she was advised that she can.</p> <p>On 2/16/2024 at 2:40pm: 24 staples were removed, resident tolerated it well. Incision is approximated and no dehiscence (dehiscence) noted.</p> <p>On 2/16/2024 at 2:44pm: (V6) is here to assess and take pictures to the right hip incision to send to (V15).</p> <p>On 2/16/2024 at 3:05pm: (V6) gave an order (from V15) to start the following orders: Cefadroxil Oral Capsule 500 mg (milligrams) one tablet twice daily, (and) to the right hip incision: Cleanse wound with wound cleanser, apply (skin barrier) to peri (perimeter of) wound, apply triple antibiotic ointment, cover with abdominal pad and secure with gauze and tape.</p> <p>R1's February 2024 Medication Administration Record (MAR) documented an order with a start date of 2/17/24 at 8:00am for Cefadroxil Oral Capsule Give 500 mg by mouth every morning and at bedtime for infection to right hip for 7 Days.</p> <p>A Physician's Note from V15 dated 2/19/24 documented, Patient (R1) has superficial irritation and/or infection at staple sites. Wound appears better today than it did on 2/16, now that staples are out. Contact (V14, Medical Doctor) regarding bilateral leg edema. Continue (Cefadroxil) 500mg BID (twice daily) until one week course completed. Return to office in one week if wound looks suspicious.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 6/6/24 at 1:35pm, V3, Licensed Practical Nurse/Wound Care Nurse, stated on 2/16/24 she had assessed the hip incision, which appeared red, warm, and swollen with purulent drainage, and the staples were still intact. V3 stated prior to 2/16/24 she had not evaluated or treated the wound. V3 stated one of the floor nurses, she is not sure which one, had asked her to assess the wound when it was realized it was probably infected. V3 stated V6 gave them orders from V15 to remove the staples, apply a dressing, and begin an antibiotic. V3 stated she removed the staples and applied the dressing. V3 stated she left on maternity leave on 2/17/24 and does not know anything about R1's care after that point.</p> <p>On 6/6/24 at 2:45pm, V2, Director of Nurses, stated she was not very familiar with R1's care, and does not recall ever having gone into her room. V2 stated she did not know why the staples were not removed on 2/8/24 as ordered. V2 stated to her knowledge, the issue was not identified until V3 evaluated the wound on 2/16/24. V2 stated the issue was discussed in the facility's Quality Assurance Meeting but the root cause of the failure was not determined. V2 stated when she reviewed the discharge summary, the orders were confusing as they were to take the staples out on 2/8/24 but leave the dressing in place for 7 days, which would have been 2/12/24. V2 stated an x-ray was ordered for 2/8/24 but was not done due to scheduling problems with the x-ray provider. V2 stated the x-ray was finally done on 2/11/24. V2 confirmed staff had not contacted V15 to clarify the discharge orders nor report that a portable x-ray could not be done, but they should have.</p> <p>On 6/11/24 at 8:00am, V6 stated that V15 was currently on vacation and would be unable to speak to the Surveyor. V6 confirmed the office was called on 2/16/24 and she inspected the incision as stated in the Nursing Progress Notes. V6 stated when she saw the wound, the staples had been removed, and the incision was reddened and obviously irritated at the sites where the staples had been. V6 stated she took photos of the wound and V15 reviewed the photos and V15 stated to V6 that the staples being left in too long had caused it to get irritated and infected, and he ordered an antibiotic. V6 stated the facility staff had also told her the x-ray had not been done on 2/8/24 as ordered. V6 stated V15's standard orders on hip replacement surgery are to leave the dressing in place for 7 days after the surgery, then at that time get the x-ray and remove the staples. V6 confirmed the staples were to have been removed and an x-ray obtained on 2/8/24. V6 stated upon discharge, the resident did not need to make an appointment with V15 unless there were problems, but since the incision had become infected V15 had seen R1 on 2/19/24. V6 stated staff should have called to say the x-ray could not be done on the date it was ordered, but they did not. V6 further stated the facility could have called them to clarify the orders if needed but they did not.</p> <p>On 6/11/24 at 10:00am, V1, Administrator, stated the facility does not have policies for surgical wound care, following physician's orders, or readmitting residents following hospitalization .</p> | | |