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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 06/25/2024 |
| 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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32765</p> <p>Based on interview and record review the facility failed to ensure residents were free from verbal abuse for 1 of 3 (R3) residents reviewed for abuse in a sample of 11. This failure resulted in (V21), Registered Nurse telling R3 to go away and get lost she was too tired for this nonsense and if he didn't she was going to kick him in the forehead. This would cause a reasonable person to react with feelings of fear, anxiety, and humiliation.</p> <p>This past non-compliance occurred between 5/26/24 and 5/28/24.</p> <p>Findings Include:</p> <p>The initial incident report received by the Illinois Department of Public Health on 5/26/24 documents an incident date of 5/26/24. The Initial Incident Description documents Resident: (R3). The purpose of this letter is to notify the Department of allegations reported by staff regarding alleged verbal abuse between a nurse and resident.</p> <p>The untitled document dated 5/31/24 documents it is the Final report of an abuse allegation related to R3. This same report documents, It was immediately reported to the Director of Nursing that (R3) had propelled himself to the nurse's desk where two staff members were sitting and asked if they knew anything about small motors. The C.N.A. (Certified Nursing Assistant-V4) sitting at the desk reported it was at that time the Registered Nurse (V21) said to the resident (R3) 'go away, and get lost, I am too tired for this nonsense.' She also stated that if he didn't, she would 'kick him in the forehead.' This nurse was immediately suspended, and her agency was notified of the incident. POA (power of attorney), ombudsman, local police, and MD (physician) were notified. An investigation was initiated. (R3) was interviewed. He does not recall the incident. Staff were interviewed. Other than the staff member reporting the incident, no one had knowledge of the incident and reported that they have not heard or observed (V21) be abusive. Residents were interviewed. Residents had no concerns regarding care by this nurse. Residents interviewed were not aware of any abuse. Following the investigation, based on statements, the facility substantiated the allegation. The abuse was reported to the agency she (V21) works for. She was put on a DO NOT return list for our facility. Social services will follow up with (R3) twice a week for 30 days to ensure no further issues.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>R3's Admission Record with a print date of 6/24/24 documents R3 was admitted to the facility on [DATE] with diagnoses that include heart disease, dementia, anxiety disorder, and mild cognitive impairment. R3's Minimum Data Set, dated dated [DATE] documents R3 has a severe cognitive impairment.</p> <p>R3's current undated Care Plan documents a Focus area of (R3) has a potential psychosocial well-being problem .5/27/24 (R3) was in an incident with a staff member with an allegation of verbal abuse The Interventions include, Social services will meet with (R3) twice weekly for 60 days to ensure he has no effects of alleged verbal abuse.</p> <p>On 6/20/24 at 2:53 PM, V4 (Certified Nursing Assistant/CNA) stated she was working with V21 (RN/Registered Nurse) and she had been stand-offish towards the residents. V4 stated she was sitting at the nurse's station charting and R3 rolled behind the desk and was sitting next to her. V4 stated R3 asked if they knew anything about small motors and V21 stated to R3, get out of here. V4 stated she suggested R3 go to his room or the dining room. V4 stated R3 stayed at the nurse's station and V21 told R3, I said get out of here, go on, get. V4 stated then V21 stated, If you don't get out of here on the count of 5, I am going to kick you in the forehead. V4 stated V21 then said and you don't know how high I can jump. V4 stated she backed R3 up and rolled him to his room and asked him to stay there. V4 stated she answered a call light and told V21 she would be back. V4 stated she went to the other hall and told the other nurse what had happened who reported it to the charge nurse. V4 stated the administrator was called and the other nurse's working walked V21 to the conference room. V4 stated they talked with V21 and then walked with her down the hall to do a narcotics count before walking her out the door. When asked if she felt like what occurred was abuse, V4 stated, Yes, the look on her (V21) face made it look like she meant it. V4 stated it was a hey, get away from me or else I am going to hurt you. When asked if she felt like the facility handled it appropriately, V4 stated, Yes, they walked her out. V4 stated as far as she knows V21 had not been back to the facility.</p> <p>The untitled statement included in the abuse investigation signed by V21 (RN,Registered Nurse) documents, (R3) approached desk CNA and nurse were at. He (R3) said something very sexual. I was upset, as I've been assaulted before and have not slept in nearly 24 hours. I don't recall what I said beyond trying to get him away</p> <p>On 6/25/24 at 2:03 PM, V2 (Director of Nurses) stated administration was notified V21 had threatened to kick R3 in the forehead. V2 stated they immediately got V21 and had her count narcotics with another nurse, and then sent V21 home. V2 stated they contacted V21's agency employer and told them they had sent her home due to an allegation of abuse. V2 stated they started the investigation and determined abuse had occurred. V2 stated they notified V21's employer that the allegation was founded. V2 stated V21 said she didn't recall her exact words to R3. V2 stated they educated all staff on abuse/neglect on 5/27/24, they conducted a QAPI (Quality Assurance and Performance Improvement) meeting on 5/28/24, interviewed the residents on 5/27/24, and are completing on-going audits.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility Abuse, Prevention and Prohibition Policy dated 01/24 documents, 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 of other agencies serving the resident, family members or legal guardians, friends, or other individuals. Policy: This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility will educate all employees upon hire and at least annually of the definitions of the Abuse Prevention and Prohibition Policy including definitions pertaining to abuse and neglect. Annually, the Administrator will contact local law enforcement to review the requirements for reporting to law enforcement. Under Prevention the policy documents, the resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion. The owner, licensee, Administrator, employee, or agent of the facility shall not abuse or neglect a resident and must prohibit the misappropriation of resident property</p> <p>Prior to the survey date, the facility took the following actions to correct the deficient practice:</p> <ol style="list-style-type: none"> 1. R3 was assessed and no injuries were noted. R3 was interviewed and does not recall the incident. 2. The nurse, V21 was immediately sent home. 3. Direct care staff were provided education on the abuse policy and customer service on 5/27/24. 4. All residents have the potential to be affected by the alleged deficient practice. Only one (R3) was identified. 5. Ad hoc QAPI (Quality Assurance and Performance Improvement) meeting held on 5/28/24, with the IDT (Interdisciplinary) team, the plan to address the area of concern was discussed. 7. On 5/26/24 and 5/27/24 interviewed all alert residents on (R3's) hall to ask if they have had any issues with staff abuse. 6. Administrative team will monitor 3 times weekly for 60 days using monitoring form designated for this PNC (past non-compliance). All patterns and trends will be brought to QAPI for changes as needed. |