

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 02/18/2025
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.

(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 - 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** 32619</p> <p>Based on interview and record review, the facility failed to prevent peer to peer sexual abuse for 1 of 4 residents (R1) reviewed for abuse in the sample of 4. This failure resulted in R1, who is cognitively impaired and incapable of giving informed consent to inappropriate sexual touching and having unsolicited sexual comments directed toward her. These actions would cause a reasonable person to experience feelings of guilt, embarrassment, anger, and shame.</p> <p>Findings include:</p> <p>R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Osteoarthritis and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 has severe impaired cognition.</p> <p>R2's Face Sheet documented an admitted [DATE] and listed diagnoses including Diabetes Type 2 and End Stage Renal Disease Dependent on Dialysis. R2's MDS dated [DATE] documented a BIMS score of 14, indicating R2 is cognitively intact.</p> <p>R2's Nursing Progress Notes, authored by V9, Licensed Practical Nurse, documented the following:</p> <p>1/11/25 at 12:25pm: (R2) is in common area visiting with a female resident . (R2) is rubbing up her right leg and arm and sweet talking her. Separated patients, asked female if she needed any help, female said she did not know who he was, but was not upset, but wanted separated. Staff took her to dining area for lunch. Will continue to monitor.</p> <p>1/11/25 at 12:53pm: (R2) propelled self to dining area found same female patient. Female patient had her leg up on a chair and (R2) was rubbing her leg and above knee, he pulled her pant leg up. Touching inappropriately. Immediately separated again. Took female to different table different location. Had CNA (Certified Nursing Assistant) stay close by female. Asked female if she was upset about him touching her leg. She said she was not and didn't know who he was.</p> <p>1/11/25 at 2:27pm: (R2) started to propel self to female patient again by common area. I told (R2) to keep his hands to himself and not touch her. He yelled at me that he planned on keeping his hands to himself and to leave him alone.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's (Psychiatric Provider) Visit-Mental Status Exam dated 1/23/25 documented, (Daughter) notes variable cognitive function as does facility with sundowning like behavior and significant confusion which appears randomly and not associated with dialysis days or otherwise. Per facility reports, has increased fixation on another female resident, has noted this behavior within the last couple of weeks, last noted per chart review was 1/11/25. Increased sexual comments toward female staff, never attempting to make physical contact, last noted chart review was 1/12/25. Increased aggression and combativeness noted on 1/19/25, at this time he was noted to be actively exit seeking. Care Plan: Increase Sertraline to 100mg daily and add Hydroxyzine (antihistamine) 10mg one tablet every 6 hours as needed for agitation for 14 days while dosage adjustment is ongoing.</p> <p>On 2/14/25 at 1:45pm, V9, Licensed Practical Nurse, stated the female resident referred to in the 1/11/25 Nurse's Notes is R1. V9 stated, It was inappropriate of a man to touch a woman's leg, but she (V9) did not see it as sexual abuse as they were both clothed and he was just talking to her. V9 stated 1/11/25 was on a Saturday, and she reported the incident to either V2, Director of Nurses, or V7, Assistant Director of Nurses, one or the other of which was the Weekend Manager on Duty.</p> <p>On 2/14/25 at 9:20am, V7, Assistant Director of Nurses, stated she recalls in early January 2025 one of the nursing staff, whose identity she can't remember, had notified V7 that R2 was pushing R1 down the hall in her wheelchair, and V7 told staff to separate them as R2's gait is unsteady and both residents are a fall risk. V7 stated on 1/13/24, V3 and another CNA, possibly V4, told V7 that R2 had been seeking R1 out, talking to her, and getting possessive of her. V7 stated she notified V6, Social Services Designee, to begin tracking R2 for behaviors related to R1. V7 stated R2 had a history of being sexually inappropriate with staff, but not peers, so she did not think this behavior would progress into sexual abuse.</p> <p>On 2/13/25 at 10:40am, V3, Certified Nursing Assistant (CNA), stated on 1/28/25, R1 was sitting in her wheelchair in the doorway of her room as she enjoys doing. V3 stated he then witnessed R2, who had been self-propelling in the hallway, lift R1's shirt and touch R1's breast. V3 stated he and V4, CNA, who also witnessed the incident, immediately separated the residents and then immediately reported it to V2, Director of Nurses, as V1, Administrator was off that day. V3 stated both residents were separated for the remainder of the day. V3 stated he had not witnessed R2 ever act out in this way, but V3 stated he had previously reported to nursing staff that he felt R2 was showing too much interest in R1, seeking her out, trying to hold her hand, and being possessive of her. V3 stated the ongoing interventions in relation to R1 and R2 are to separate them if they are seen in close proximity.</p> <p>On 2/13/25 at 11:00am, V4, CNA, corroborated V3's account of the incident on 1/28/25. V4 stated as staff were separating R1 and R2, V4 heard R2 say to R1, Lets go have sex. V4 stated she had been, Noticing they (R1 and R2) had been becoming 'too friendly' for a couple weeks. V4 stated she has not known R2 to display this behavior toward peers, but he is very inappropriate with female staff, attempting to touch their breasts and buttocks and making sexual comments. V4 stated when transferring R2 the morning of 2/13/25, R2 had grabbed V4's buttocks, and when she pointed out the behavior, R2 stated, Yes I know, it was intentional. V4 stated interventions to prevent further abuse is that if R1 and R2 are seen in close proximity they are to be separated, and they are not to be seated together in the dining room or common areas.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/25 at 11:40am, V9, Licensed Practical Nurse, stated when she worked on 1/30/25, she heard about the incident in report. V9 corroborated V3 and V4's account of noticing R2 seeking R1 out, and We told the supervisors. V9 stated after the 1/28/25 incident, R2 has stated to her that, 'I know you're watching me and I don't have a woman in my room.' V9 stated R1 and R2 are no longer on 15 minute checks nor have either been on one on one monitoring. V9 stated staff are to, Monitor him (R2) and keep an eye on where he's going, and separate him from any female residents.</p> <p>R2's Progress Notes also document the following:</p> <p>1/30/25 at 4:00pm, authored by V9: Following female residents around. CNA's helped him into recliner to rest.</p> <p>1/30/25 at 4:30pm, authored by V2, Director of Nurses: After talking to CNA's it was noted that (R2) was behind a female resident in the hallway. He stopped to talk to her but there was no inappropriate actions and he did not make any inappropriate comments.</p> <p>On 2/13/25 at 12:40pm, V6, Social Services Designee, stated after the incident on 1/28/25, R2's Care Plan was updated to include the potential for sexual acting out behavior, and this was also added to R2's behavior tracking. V6 stated R2 has not had any further behaviors of this type.</p> <p>On 2/13/25 at 1:25pm, V2, Director of Nurses, stated CNA staff reported the incident on 1/28/25 to her immediately, and the residents had already been separated. V2 stated she began an immediate investigation in the absence of V1, who is the facility's Abuse Coordinator. V2 stated R1 and R2 were both placed on 15 minute checks. V2 stated R1 was moved to be closer to the nurse's station, and R2's Psychiatric Nurse Practitioner was contacted and gave an order to change his Hydroxyzine to 10mg one tablet twice daily. V2 stated both residents were assessed, and neither was injured. V2 stated immediately following the incident, neither resident remembered it. V2 stated none of the staff had informed her before the incident that R2 had been seeking R1 out. V2 stated R1 is always confused and R2 has periods of confusion especially during the evening with sundowning behavior.</p> <p>On 2/14/25 at 10:50am, V10, R1's Family Member, stated he was contacted about the incident on 1/28/25 by V2. V10 stated the solution the facility came up with was to move R1 to a room closer to the nurse's station. V10 stated he feels uneasy about R2 still moving freely about the facility, and potentially able to sexually abuse R1 or other female residents. V10 stated R1 is extremely confused and as such she is not capable of giving consent to sexual activity. V10 stated if R1 was not confused, she would not have agreed to sexual activity, and, She would have been extremely upset and angry, she would have been embarrassed, and she probably would have punched him (R1) in the throat.</p> <p>R1's Care Plan dated 1/31/25 documented a problem area, The resident has a behavior problem 1/28/25, (R1) involved in a resident to resident touching incident with corresponding interventions, Changed (R1's) room, added 1/28/25, and Every 15 minute checks for 24 hours, added 1/28/25.</p> <p>R2's Care Plan dated 1/31/25 documented a problem area, (R2) may display inappropriate sexual behavior, may make sexually inappropriate comments, with corresponding interventions, 1. Remove (R1) from the environment; 2. Ensure others safety- remove other resident from environment. 3. Ensure (R1's) safety. 4. Encourage to discuss feelings. 5. Try a different caregiver. 6. Offer to call family.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/25 at 9:45am, R1 was observed lying in her bed. R1 was alert only to herself, R1 could only give her name, and could not give the date or the name of the facility.</p> <p>On 2/13/25 at 9:55am, R2 was observed up in a wheelchair in his room. R2 stated he is currently in a hospital, gave the date as February 2024 date and day of the week unknown, but could name the current President. R2 stated he does like to self-propel out of his room and go out into the hall and dining room. When asked if R2 had displayed any sexually inappropriate behavior toward residents or staff, R2 stated I assume you mean molesting. Anytime I am alone with a woman, staff finds a reason to separate us. They don't like us being more than friends. When asked if there are any female peers with whom he is more than friends, R2 stated, There is one lady, they thought we were too close, I can't remember her name, but anyway nothing happened. R2 denied touching any peers inappropriately, nor any peers touching him inappropriately.</p> <p>A Final Report submitted to Illinois Department of Public Health (IDPH) dated 2/3/25 documented, The purpose of this letter is to notify the Department of our conclusion of an incident that occurred in the facility on 1/28/25. (R2) was in his wheelchair in the hall. He was observed stopping near (R1) and placed his hand under her shirt and touched her breast. (R1) then placed her hand in (R2's) lap. They were immediately separated by staff. As staff were separating them, (R1) stated, That's my boyfriend. Licensed staff initiated a head to toe assessment on both residents noting no injury.</p> <p>The facility's Abuse, Prevention, and Prohibition Policy dated December, 2024 documented, 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. Resident capacity to consent to sexual activity: Generally, sexual contact is nonconsensual if the resident either appears to want the contact to occur, but lacks cognitive ability to consent, or does not want the contact to occur.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619</p> <p>Based on interview, observation, and record review, the facility failed to report to the facility Administrator or his/her designated representative an incident of peer to peer sexual abuse for 1 of 4 residents (R1) reviewed for abuse in the sample of 4.</p> <p>Findings include:</p> <p>R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Osteoarthritis and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 has severe impaired cognition. The same MDS documented that R1 is dependent on staff for transfers and wheelchair mobility. R1's Care Plan dated 1/31/25 documented a problem area, The resident has a behavior problem 1/28/25, (R1) involved in a resident to resident touching incident with corresponding interventions, Changed (R1's) room, added 1/28/25, and Every 15 minute checks for 24 hours, added 1/28/25.</p> <p>R2's Face Sheet documented an admitted [DATE] and listed diagnoses including Diabetes Type 2 and End Stage Renal Disease Dependent on Dialysis. R2's MDS dated [DATE] documented a BIMS score of 14, indicating R2 is cognitively intact. The same MDS documented that R2 uses a manual wheelchair independently. R2's Care Plan dated 1/31/25 documented a problem area, (R2) may display inappropriate sexual behavior, may make sexually inappropriate comments, with corresponding interventions, 1. Remove (R1) from the environment; 2. Ensure others safety- remove other resident from environment. 3. Ensure (R1's) safety. 4. Encourage to discuss feelings. 5. Try a different caregiver. 6. Offer to call family.</p> <p>R2's Nursing Progress Notes, authored by V9, Licensed Practical Nurse, documented the following:</p> <p>1/11/25 at 12:25pm: (R2) is in common area visiting with a female resident. (R2) is rubbing up her right leg and arm and sweet talking her. Separated patients, asked female if she needed any help, female said she did not know who he was, but was not upset, but wanted separated. Staff took her to dining area for lunch. Will continue to monitor.</p> <p>1/11/25 at 12:53pm: (R2) propelled self to dining area found same female patient. Female patient had her leg up on a chair and (R2) was rubbing her leg and above knee, he pulled her pant leg up. Touching inappropriately. Immediately separated again. Took female to different table different location. Had CNA (Certified Nursing Assistant) stay close by female. Asked female if she was upset about him touching her leg. She said she was not and didn't know who he was.</p> <p>1/11/25 at 2:27pm: (R2) started to propel self to female patient again by common area. I told (R2) to keep his hands to himself and not touch her. He yelled at me that he planned on keeping his hands to himself and to leave him alone.</p> <p>There was no documentation in the medical record to indicate these interactions were reported to the facility's Abuse Coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/25 at 9:45am, R1 was observed lying in her bed. R1 was alert only to herself, R1 could only give her name, and could not give the date or the name of the facility.</p> <p>On 2/13/25 at 9:55am, R2 was observed up to the wheelchair in his room. R2 stated he is currently in a hospital, gave the date as February 2024 date and day of the week unknown, but could name the current President. R2 stated he does like to self-propel out of his room and go out into the hall and dining room. When asked if R2 had displayed any sexually inappropriate behavior toward residents or staff, R2 stated I assume you mean molesting. Anytime I am alone with a woman, staff finds a reason to separate us. They don't like us being more than friends. When asked if there are any female peers with whom he is more than friends, R2 stated, There is one lady, they thought we were too close, I can't remember her name, but anyway nothing happened. R2 denied touching any peers inappropriately, nor any peers touching him inappropriately.</p> <p>On 2/14/25 at 1:45pm, V9 stated the female resident referred to in the 1/11/25 Nurse's Notes is R1. V9 stated, It was inappropriate of a man to touch a woman's leg, but she (V9) did not see it as sexual abuse as they were both clothed and he was just talking to her. V9 stated 1/11/25 was on a Saturday, and she reported the incident to either V2, Director of Nurses, or V7, Assistant Director of Nurses, one or the other of which was the Weekend Manager on Duty.</p> <p>On 2/14/25 at 1:55pm, V1, Administrator, confirmed she is the facility's Abuse Coordinator. V1 stated she had not been made aware of the interactions between R1 and R2 as outlined in R2's Nurse's Notes on 1/11/25, and there was no abuse investigation initiated. V1 stated V9 did not believe the interactions qualified as sexual abuse. V1 stated even if V9 reported it to V2 or V7, V9 should have immediately reported it to V1.</p> <p>On 2/14/25 at 9:20am, V7, Assistant Director of Nurses, stated she recalls in early January 2025 one of the nursing staff, whose identity she can't remember, had notified V7 that R2 was pushing R1 down the hall in her wheelchair, and V7 told staff to separate them as R2's gait is unsteady and both residents are a fall risk. V7 stated on 1/13/24, V3 and another CNA, possibly V4, told V7 that R2 had been seeking R1 out, talking to her, and getting possessive of her. V7 stated she notified V6, Social Services Designee, to begin tracking R2 for behaviors related to R1. V7 stated R2 had a history of being sexually inappropriate with staff, but not peers, so she did not think this behavior would progress into sexual abuse.</p> <p>The facility's Abuse, Prevention, and Prohibition Policy dated December, 2024 documented The facility Administrator will be designated as the facility's Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. Reporting/Response: The facility employee or agent who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility Administrator or his/her designated representative in the Administrators absence.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</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 report, investigate, and further prevent peer to peer sexual abuse for 1 of 4 residents (R1) reviewed for abuse in the sample of 4.</p> <p>Findings include:</p> <p>R1's Face Sheet documented an admitted [DATE] and listed diagnoses including Osteoarthritis and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 has severe impaired cognition. The same MDS documented that R1 is dependent on staff for transfers and wheelchair mobility. R1's Care Plan dated 1/31/25 documented a problem area, The resident has a behavior problem 1/28/25, (R1) involved in a resident to resident touching incident with corresponding interventions, Changed (R1's) room, added 1/28/25, and Every 15 minute checks for 24 hours, added 1/28/25.</p> <p>R2's Face Sheet documented an admitted [DATE] and listed diagnoses including Diabetes Type 2 and End Stage Renal Disease Dependent on Dialysis. R2's MDS dated [DATE] documented a BIMS score of 14, indicating R2 is cognitively intact. The same MDS documented that R2 uses a manual wheelchair independently. R2's Care Plan dated 1/31/25 documented a problem area, (R2) may display inappropriate sexual behavior, may make sexually inappropriate comments, with corresponding interventions, 1. Remove (R1) from the environment; 2. Ensure others safety- remove other resident from environment. 3. Ensure (R1's) safety. 4. Encourage to discuss feelings. 5. Try a different caregiver. 6. Offer to call family.</p> <p>R2's Nursing Progress Notes, authored by V9, Licensed Practical Nurse, documented the following:</p> <p>1/11/25 at 12:25pm: (R2) is in common area visiting with a female resident. (R2) is rubbing up her right leg and arm and sweet talking her. Separated patients, asked female if she needed any help, female said she did not know who he was, but was not upset, but wanted separated. Staff took her to dining area for lunch. Will continue to monitor.</p> <p>1/11/25 at 12:53pm: (R2) propelled self to dining area found same female patient. Female patient had her leg up on a chair and (R2) was rubbing her leg and above knee, he pulled her pant leg up. Touching inappropriately. Immediately separated again. Took female to different table different location. Had CNA (Certified Nursing Assistant) stay close by female. Asked female if she was upset about him touching her leg. She said she was not and didn't know who he was.</p> <p>1/11/25 at 2:27pm: (R2) started to propel self to female patient again by common area. I told (R2) to keep his hands to himself and not touch her. He yelled at me that he planned on keeping his hands to himself and to leave him alone.</p> <p>There was no documentation in the medical record to indicate these interactions were reported to the facility's Abuse Coordinator.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's (Psychiatric Provider) Visit-Mental Status Exam dated 1/23/25 documented, (Daughter) notes variable cognitive function as does facility with sundowning like behavior and significant confusion which appears randomly and not associated with dialysis days or otherwise. Per facility reports, has increased fixation on another female resident, has noted this behavior within the last couple of weeks, last noted per chart review was 1/11/25. Increased sexual comments toward female staff, never attempting to make physical contact, last noted chart review was 1/12/25. Increased aggression and combativeness noted on 1/19/25, at this time he was noted to be actively exit seeking. Care Plan: Increase Sertraline to 100mg daily and add Hydroxyzine (antihistamine) 10mg one tablet every 6 hours as needed for agitation for 14 days while dosage adjustment is ongoing.</p> <p>On 2/14/25 at 1:45pm, V9, Licensed Practical Nurse, stated the female resident referred to in the 1/11/25 Nurse's Notes is R1. V9 stated, It was inappropriate of a man to touch a woman's leg, but she (V9) did not see it as sexual abuse as they were both clothed and he was just talking to her. V9 stated 1/11/25 was on a Saturday, and she reported the incident to either V2, Director of Nurses, or V7, Assistant Director of Nurses, one or the other of which was the Weekend Manager on Duty.</p> <p>On 2/14/25 at 9:20am, V7, Assistant Director of Nurses, stated she recalls in early January 2025 one of the nursing staff, whose identity she can't remember, had notified V7 that R2 was pushing R1 down the hall in her wheelchair, and V7 told staff to separate them as R2's gait is unsteady and both residents are a fall risk. V7 stated on 1/13/24, V3 and another CNA, possibly V4, told V7 that R2 had been seeking R1 out, talking to her, and getting possessive of her. V7 stated she notified V6, Social Services Designee, to begin tracking R2 for behaviors related to R1. V7 stated R2 had a history of being sexually inappropriate with staff, but not peers, so she did not think this behavior would progress into sexual abuse.</p> <p>A Final Report submitted to Illinois Department of Public Health (IDPH) dated 2/3/25 documented, The purpose of this letter is to notify the Department of our conclusion of an incident that occurred in the facility on 1/28/25. (R2) was in his wheelchair in the hall. he was observed stopping near (R1) and placed his hand under her shirt and touched her breast. (R1) then placed her hand in (R2's) lap. They were immediately separated by staff. As staff were separating them, (R1) stated, That's my boyfriend. Licensed staff initiated a head to toe assessment on both residents noting no injury.</p> <p>On 2/13/25 at 10:40am, V3, Certified Nursing Assistant (CNA), V3 stated he had previously reported to nursing staff that he felt R2 was showing too much interest in R1, seeking her out, trying to hold her hand, and being possessive of her. V3 stated the ongoing interventions in relation to R1 and R2 are to separate them if they are seen in close proximity.</p> <p>On 2/13/25 at 11:00am, V4 stated she had been, Noticing they (R1 and R2) had been becoming 'too friendly' for a couple weeks. V4 stated she has not known R2 to display this behavior toward peers, but he is very inappropriate with female staff, attempting to touch their breasts and buttocks and making sexual comments. V4 stated when transferring R2 the morning of 2/13/25, R2 had grabbed V4's buttocks, and when she pointed out the behavior, R2 stated, Yes I know, it was intentional. V4 stated interventions to prevent further abuse is that if R1 and R2 are seen in close proximity they are to be separated, and they are not to be seated together in the dining room or common areas.</p> <p>On 2/13/25 at 12:40pm, V6, Social Services Designee, stated after the incident on 1/28/25, R2's Care Plan was updated to include the potential for sexual acting out behavior, and this was also added to R2's behavior tracking. V6 stated R2 has not had any further behaviors of this type.</p> <p>(continued on next page)</p>		

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 02/18/2025
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/25 at 1:25pm, V2, Director of Nurses, stated CNA's staff reported the 1/28/25 incident to her immediately, and the residents had already been separated. V2 stated she began an immediate investigation in the absence of V1, who is the facility's Abuse Coordinator. V2 stated to her knowledge, R2 had no previous history of peer to peer sexually inappropriate behavior. When asked what ongoing interventions are in place to prevent further abuse, V2 stated staff are to, Make sure he (R2) is not near any female residents and check on him, not necessarily within any specific time frame. But if staff are going by his room, they are to look in and see what he's doing and if he has any more sexual behaviors, staff are to report it to me. V2 stated none of the staff had informed her before the 1/28/25 incident that R2 had been seeking R1 out. V2 stated when R2 was seen on 1/30/25 following female residents around, he was not placed back on 15 minute checks. V2 stated at no time was R2 getting one to one staff supervision. V2 stated, We don't provide that here, if a resident needs one on one, we notify the family that they will need to provide it.</p> <p>On 2/14/25 at 1:55pm, V1, Administrator, confirmed she is the facility's Abuse Coordinator. V1 stated she had not been made aware of the interactions between R1 and R2 on 1/11/25, and there was no abuse investigation initiated. V1 stated V9 did not believe the interactions qualified as sexual abuse. V1 stated even if V9 reported it to V2 or V7, V9 should have immediately reported it to V1.</p> <p>On 9:45am at 2/13/25, R1 was observed lying in her bed. R1 was alert only to herself, R1 could only give her name, and could not give the date or the name of the facility.</p> <p>On 2/13/25 at 9:55am, R2 was observed up to the wheelchair in his room. R2 stated he is currently in a hospital, gave the date as February 2024 date and day of the week unknown, but could name the current President. R2 stated he does like to self-propel out of his room and go out into the hall and dining room. When asked if R2 had displayed any sexually inappropriate behavior toward residents or staff, R2 stated I assume you mean molesting. Anytime I am alone with a woman, staff finds a reason to separate us. They don't like us being more than friends. When asked if there are any female peers with whom he is more than friends, R2 stated, There is one lady, they thought we were too close, I can't remember her name, but anyway nothing happened. R2 denied touching any peers inappropriately, nor any peers touching him inappropriately.</p> <p>The facility's Abuse, Prevention, and Prohibition Policy dated December, 2024 documented, Investigation: Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While a facility investigation is underway, steps will be taken to prevent further abuse. Resident Capacity to Consent to Sexual Activity: Generally, sexual contact is nonconsensual if the resident either appears to want the contact to occur, but lacks cognitive ability to consent, or does not want the contact to occur. The facility Administrator will be designated as the facility's Abuse Coordinator and will be responsible for overseeing the Abuse Prevention and Prohibition Program and directing any abuse investigation. Reporting/Response: The facility employee or agent who becomes aware of abuse or neglect, including injuries of unknown origin or alleged misappropriation of resident property, shall immediately report the matter to the facility Administrator or his/her designated representative in the Administrators absence.</p>		