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	04/13/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the family of a change in condition for 1 (R1) of 3 residents reviewed for notification of changes in the sample of 4. The Findings Include:R1's admission Record documented an admission date of 09/17/2024 and included diagnoses of acute osteomyelitis of right ankle and foot, chronic obstructive pulmonary disease, type 2 diabetes mellitus, generalized anxiety, end stage renal disease, chronic diastolic heart failure, anemia in chronic kidney disease, and dependance on renal dialysis.R1's Care Plan documented a focus area of R1 needs dialysis related to renal failure. Corresponding intervention included, do not draw blood or take blood pressure in the right arm with graft, encourage resident to go for the scheduled dialysis appointments on Monday, Wednesday, and Friday, and monitor labs and report to the doctor as needed.R1's Progress Note dated 03/27/2026 with a time of 4:58 A.M. authored by V8 (Licensed Practical Nurse/LPN) documented R1 refused to get up for dialysis treatment this morning. R1's Progress Note dated 03/30/2026 with a time of 5:24 A.M. authored by V9 (LPN) documented R1 refused multiple attempts to take R1 to dialysis by 4 staff members.R1's Progress Note dated 03//31/2026 with a time of 9:09 A.M. authored by V2 (Director of Nursing/DON) documented V4 (Family Member/Power of Attorney/POA) was notified R1 has refused to go to dialysis. Will wait return call.On 04/09/2026 at 4:17 PM, V3 (Family Member) stated R1 was in the facility for 18 months. V3 stated the facility did not notify V3, V4 (POA) or V5 (Family Member) of R1's refusal to go to dialysis. V3 stated the facility usually called every time there was a change in R1. V3 stated on 03/27/2026, R1 refused to go to dialysis and the facility did not call. V3 stated on 03/27/2026 at 11:30 AM, V5 was in the facility for R1's hearing aide consult and no one from the facility told V5 that R1 did not go to dialysis that day. V3 stated that V5 was in the facility on 03/29/2026 around breakfast time and no staff told her then that R1 did not go to dialysis on 03/27/2026. V3 stated no one was notified on 03/30/2026 that R1 did not attend dialysis that day. V3 said on 03/31/2026, V2 (DON) called V4 and explained that R1 had refused dialysis and was pretty confused and wanted a referral to hospice. V3 stated that V5 had called the dialysis center on 03/30/2026 and confirmed R1 had missed two treatments and that on 03/25/202, R1 became unruly and his treatment was cutoff an hour earlier than usual. V3 stated the facility did not notify them of this either. V3 stated she feels like the facility took away their ability to talk to R1 when he was more alert because they had not notified the family of the dialysis refusals.On 04/10/2026 at 1:09 PM, V1 (Administrator) stated she was not aware R1 did not complete his entire treatment on 03/25/2026. V1 stated the family and physician should both be made aware when a resident refuses dialysis or any other medication or treatment. On 04/10/2026 at 1:27 PM, V2 (DON) stated she notified the family as soon as she was made aware that R1 had been refusing his dialysis treatments. V2 stated she called the family because when she looked at the chart, there was no documentation of R1's family or physician being notified. V2 stated she is not sure that the doctor was notified because there is no documentation of it. V2 stated all staff should know to notify the physician and the family when a resident refuses care, treatments and especially dialysis. V2 stated it is her expectation that nursing staff follow the policy and notify family and physicians when there is a change in condition. On 04/10/2026 at 1:52 PM, V9 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(LPN) stated she was R1's nurse the morning of 03/30/2026. V9 stated R1 was up in his wheelchair and when the transport driver came to take him to dialysis, R1 refused to go. V9 stated she attempted to get him to go as well as 3 other staff members. V9 stated all attempts were unsuccessful. V9 stated she passed it on in report that R1 had refused to go to dialysis and that she had not notified the physician or the family. V9 stated she thought the oncoming nurse would notify the family and the physician. V9 stated that she probably should have been the one to notify the family and the physician. V9 stated she is not sure what the policy states about notification.On 04/10/2026 at 2:00 PM, V8 (LPN) stated she was the nurse working when R1 refused to go to dialysis. V8 stated she did not notify the family because R1 was alert and oriented and could make his own decisions. V8 stated she thinks she notified the physician, but she did not document it. V8 stated she is not aware what the policy says about notifying the family or physician when a change happens. On 04/10/2026 at 2:32 PM, V11 (LPN) stated she was the nurse who was caring for R1 on 03/30/2026. V11 stated she does not recall the night shift nurse asking her to notify the family or physician. V11 stated she would notify the family and the physician if she would have been made aware. V11 stated anytime a resident refuses they are supposed to notify the family and the physician.A facility policy titled Significant Condition Change and Notification documented the purpose of the policy is to ensure that residents' family and/or representative and medical practitioner are notified of resident changes. Under Procedure, the policy documents calls will be made to the resident's representative until they are reached. Under Documentation, the policy documents charting will include an assessment of the resident's current status as it relates to the change of condition. Charting will be done each shift for 72 hours for residents who have a change.