

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/03/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to safely transport 1 of 3 (R1) residents reviewed for accidents in a sample of 4. This failure resulted in R1's left foot getting caught in her wheelchair wheel during transport and resulted in R1 sustaining an acute mildly displaced fracture of the distal fibula and medial malleolus of the left leg. This past non-compliance occurred from 5/16/2026 to 5/18/2026. R1's admission Record documented an admission date of 4/4/2025 with diagnoses of type two diabetes mellitus, complete atrioventricular block, chronic kidney disease, non-ST elevation myocardial infarction and weakness among others. R1's MDS (minimum data set) dated 3/23/26, documents R1 with a BIMS (brief interview for mental status) score of 10 out of 15 total which indicates R1 has moderate cognitive impairment. This same MDS documents R1 has impairment to both upper and low extremities, uses a wheelchair for locomotion and is dependent on staff for most activities of daily living, including locomotion in the wheelchair. On 6/2/2026 at 8:45am, R1 said V6 Certified Nursing Assistant (CNA) was pushing in her wheelchair to the dining room for breakfast, but R1's wheelchair footrests were not on her wheelchair. R1 said V6 was pushing her pretty fast and she could not hold her foot up and when it fell down it became caught in the wheelchair wheel and twisted. R1 said that's how her ankle broke in two places. R1 said her ankle didn't hurt at the time but started hurting right before lunch and it started to swell a bit. R1 said the nurse gave her some pain medications and called her doctor. R1 said her doctor wanted it x-rayed, and the x-ray showed it was broken in two places. On 6/3/2026 at 9:00am, V6 (CNA) said she was working on R1's hall on 5/16/2026 and was responsible for providing care to R1 that day. V6 said she and V5 (CNA) got R1 up that morning using a full body lifting machine and placed R1 into her wheelchair for the day. V6 said R1 usually has her foot pedals on her wheelchair every day, but that morning she forgot to apply them. V6 said when she pushed R1 out to the dining room, R1's left foot dropped and twisted up in the wheelchair wheel. V6 said R1 responded with ouch, that hurt when it happened but then denied any further pain at the time. V6 said after breakfast was over, R1 likes to rest in bed and visit with her roommate. V6 said V5 pushed R1 back to her room, R1 dropped her left foot again causing it to hit the floor during transport and R1's foot went under the wheelchair and bent back. V6 said R1 denied any pain at the time. V6 said they put R1 into bed and told the nurse about the incident happening again. V6 said she and V5 went to get R1 up for lunch discovered R1's left ankle looked slightly swollen but had no bruising or tenderness at the time. On 6/2/2026 at 11:15am, V5 (CNA) said she worked on R1's hallway on 5/16/26 and provided R1's care that day, along with V6 (CNA). V5 said that morning they forgot to put R1's foot pedals on her wheelchair. V5 said she feels bad about what happened to R1's foot because she really cares about R1 and never wanted her to get hurt. V5 said she was transporting R1 in her wheelchair from the dining room after breakfast, when R1 left foot dropped and went a little bit under the wheelchair. V5 said it didn't twist or get caught in the wheel as it did earlier when V6 pushed her to breakfast that morning. On 6/2/2026 at 11:00am, V3 (Licensed Practical Nurse) said he was the nurse providing care for R1 on 5/16/2026 from 6:30am until 3:00pm. V3 said the facility was not short of staff and had three Certified Nursing Assistants (CNAs) for the dayshift. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145256 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few	V3 said V6 (CNA) had transported R1 to the dining for breakfast in R1 wheelchair and did not put on the foot pedals and R1's left foot dropped down and got caught in the wheel of the wheelchair and twisted. V3 said V6 told him and he assessed R1's left foot and found nothing unusual about the foot/ankle. V3 said on the way back from breakfast, V5 (CNA) was pushing R1 back to her room to rest after breakfast and the same thing happened again. V3 said R1's foot slipped down and went under the wheelchair again. V3 said after R1 was put to bed, he assessed her left foot/ankle again and this time R1's ankle looked slightly swollen but R1 continued to deny having any pain. V3 said he notified R1's doctor and family of the incident. V3 said his shift ended around 2:30pm and V4 (LPN) took over R1's care. On 6/2/2026 at 11:45am, V4 (LPN) said V3 had reported to her the incident concerning R1. V4 said about 3:30pm, she reassessed R1 left foot and ankle and determined it was still slightly swollen with new bruising starting to emerge. V4 said R1 said she started to notice some pain in the left ankle area. V4 said she gave R1 some pain medication and called R1's doctor, who ordered mobile Xray company to come to the facility and Xray R1's left foot/ankle. V4 said the x-ray company came later that evening and R1's doctor had the results early the next morning. V4 said R1's doctor ordered an immobilizer and a stat orthopedic consult for the next day. R1's orthopedic consult office visit note dated 5/20/2026 documented the following in part: (R1) in clinic today for further orthopedic management of a left distal fibula fracture. (R1) resides at a skilled nursing facility and is wheelchair-bound, uses a (full body lifting machine) for transfers. (R1) stated she was in the wheelchair, and her footrests were not on the wheelchair at all and somehow her left foot got tangled up. X-rays done showed an obliquely oriented minimally displaced fracture of the distal fibula, she is taking (medication name) for pain. Assessment Plan for R1 included: to be placed in a tall immobilizer boot for added fracture protection and stability. The patient is non-weight bearing and wheelchair bound. Continued to use (full body lifting machine) for transfers. Return to clinic in 3 weeks to repeat x-rays of ankle at that time. Facility form titled State Report documented the following in part: Brief description of incident: resident twisted her foot/ankle during transfer, bruising to top of left foot with 3+ edema. The resident was being taken via wheelchair from the dining room to lay down after breakfast. She put her foot down and it went on the floor and went slightly backwards. When staff started to get her up for lunch the nurse was notified, and head-to-toe assessment was completed. MD (medical doctor) notified and order for x-ray received. The resident was interviewed but was unable to describe what happened. Staff were interviewed and said while being taken to her room from the dining room in her wheelchair the resident put her foot down and her foot went back. The nurse was interviewed. He stated the staff reported the resident put her foot down during transport in wheelchair and it went on the floor. She (R1) complained of discomfort. The nurse immediately completed a head-to-toe assessment and noted swelling. Nurse stated he then called the MD to notify him. The IDT (interdisciplinary team) reviewed the incident. Based on statements from staff, it was determined that the root cause of the incident was due to the resident's footrests not being placed on w/c (wheelchair). Resident placed feet on the ground as she was being pushed in w/c. The facility's investigation file included witness statements from V5 and V6. V6's written statement documented the following: 5/16/26, I (V6) was pushing (R1) down to the dining room (for breakfast) and her left foot got caught in the wheelchair wheel. (R1) laid down after breakfast and when we (V5 and V6) got her up she was complaining of pain in her ankle. V5's written statement documented the following: 5/16/26, When I (V5) brought (R1) back from dining room this morning, she put her feet down and the left one went under the wheelchair a little bit. I laid her down (after breakfast) and when I got her up for lunch she complained of pain. On 6/3/2026 at 9:45am, V1 (Administrator) said the facility did not have a policy on wheelchair usage. V1 said she expected all residents who need to have foot pedals on their wheelchairs to have them applied as needed. Prior to the survey date, the facility took the following actions to correct the noncompliance: 1. The facility held a QAPI (Quality Assurance and Performance Improvement) meeting on 5/18/2026 with V1 (Administrator), V10 (Assistant Director of Nursing), V11 (Human Resources), V12 (Minimum Data Set Coordinator), V13 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(Medical Doctor/Medical Director), V14 (Licensed Practical Nurse/Minimum Data Set Coordinator), V16 (Registered Nurse), V17 (Activities Director), V18 (admission Coordinator) and V19 (Admissions Coordinator) in attendance. The QAPI Ad Hoc form under Immediate Corrective Actions included: (R1's) care plan was reviewed, and interventions were added to ensure pedals are placed on her wheelchair for transportation, All staff that have the potential to push a resident in a wheelchair were in-serviced regarding the use of footrests on wheelchairs, with emphasis on the following: Residents must have footrests in place if they are unable to propel the wheelchair on their own and Staff members directly involved with the deficient practice received corrective action. Identifying Other with the potential to be affected: All residents that use wheelchairs for transportation have the potential to be affected by the deficient practice. Systematic Changes to ensure deficient practice does not recur: All current residents' care plans were reviewed to ensure they reflect appropriate individualized interventions, All wheelchairs were audited to ensure footrests are in place for those residents that are unable to propel themselves, Director of Nursing or designee educated all staff that interventions should be put in place to prevent resident injuries based on individual need and the interventions should be reflected on their care plan. The facility held an Ad Hoc QAPI on 5/18/2026 to discuss the identified issue and at this time it was determined that a plan would be put into place and that the facility would allege past noncompliance. An additional meeting was held to discuss the progression of the past noncompliance plan, and it was determined that the facility would allege compliance as of 5/18/2026. The Medical Director was updated on 5/18/2026 on the identified issue and the plan to address the issue and development of a past noncompliance. The medical Director was updated on the facility alleging compliance as of 5/18/2026. System Maintenance: Director of Nursing or designee will review 5 residents weekly for the next 60 days to audit that appropriate individualized safety prevention interventions are in place and reflected on the resident's care plan, Residents will be reviewed as needed and quarterly during QA weekly risk meetings to review that appropriate individualized safety prevention interventions are in place and reflected on the resident's care plan. [NAME] deficient practice will be corrected immediately. Patterns or trends will be reported to the QAPI Committee for further recommendations and follow-up. Compliance achieved 5/18/2026.2. Documentation of all residents who use wheelchairs were assessed for the need of footrests and were completed by 5/18/2026.3. Staff education/in-service documentation shows facility staff were educated on all residents should have foot pedals on wheelchairs when being pushed by staff unless they self-propel and was completed on 5/17/2026.4. Individual staff involved received corrective action completed 5/18/2026.		