Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005185	A. BUILDING: ______ B. WING ______	C 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND REHAB & HEALTHCARE CENTER	800 WEST TEMPLE STREET EFFINGHAM, IL 62401

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S 000	Initial Comments Complaint Investigation: 2453540/IL172794	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	S9999		

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resident. (Section 2-107 of the Act

These regulations were not met as evidence by :

Based on interview and record review, the facility failed to ensure residents are free from abuse for two of three residents (R2 and R6) reviewed for abuse in the sample of 3. This failure resulted in R6 experiencing having clothing placed over his mouth twice in an attempt to quiet him. A reasonable person would also experience feelings of humiliation, intimidation, fear, emotional distress, and helplessness as a result.

Findings include:

1.R6's face Sheet documented an admission date of 2/24/22, and diagnoses including Autistic Disorder, Dysphagia, Repeated Falls, and Unspecified Intellectual Disabilities.

R6's Minimum Data Set (MDS) dated for 3/12/2024, documents that R6 has a Brief Interview for Mental Status (BIMS) score of 3, indicating that R6 has severe cognitive impairment. The same MDS documents that R6 is totally dependent on at least two persons assist for upper and lower body dressing.

On 5/10/2024 at 1:40pm, attempted interview with R6 but due to severe cognitive impairment, R6 was unable to answer questions appropriately.

On 5/10/2024 at 10:26am, V1 (Administrator) stated she was notified on 4/13/2024 at approximately 9:00am by V21 (Licensed Practical Nurse/ LPN) about an allegation of abuse. The allegation of abuse involved staff V23 (Certified Nurse's Assistant/ CNA) to R6. V1 stated V21 reported the allegation of abuse to her and that

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V23 was escorted out of the facility and R6 was assessed. V1 stated that R6 is unable to recall the event due to his diagnoses and appears to be doing well. V1 stated that V23's employment was terminated due to substantiated abuse allegation. V1 stated that it was reported to her by V21 that V12 (Certified Nurse Assistant/CNA) witnessed an abuse situation between V23 and R6. V1 stated that R6 has verbal outbursts regularly due to his diagnosis and V23 covered his mouth with clothing two different times while getting him ready for supper. V1 stated that she has never had any issues with V23 having abused any residents before, and was surprised and saddened that this was reported. V1 stated that V21 had V23 leave the facility as soon as this was reported.

On 5/10/24 at 11:07AM, V12 (CNA) stated that on 4/13/24 she and V23 were assisting R6 in getting ready for supper. V12 stated that R6 was not acting different that his normal state of yelling out. V12 states that R6 at times yells and is not having any distress or pain but is just part of his verbal outbursts associated with autism. V12 stated that as she and V23 were assisting R6 with getting dressed, V23 placed his pants and shirt at two different times over his mouth to quiet him while saying "when you stop, I'll stop." V23 stated that R6 was not acting any different than normal behavior and was not harming himself or anyone. V12 feels that emotionally R6 is doing better now that V23 no longer works here. V12 stated that R6 is unable to communicate how he feels or what happened that day due to his speech impairments, but he appears to be doing well.

On 5/10/24 at 11:37AM, V21 stated that V12 came and reported the incident of abuse to her as soon as it happened. V21 stated that she

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immediately checked on R6 and he was eating dinner and appeared to be doing well and could not recall the situation. V21 stated that she then had V23 write a statement of what occurred and was walked out of the building and she reported the incident to V1 who is the abuse coordinator.

On 5/14/24 at 11:15AM, V24 (Family Member) stated that the facility reported to him on the day that the abuse occurred and told him the employee was terminated. V24 has no concerns with the facility and feels they take great care of R6.
The Abuse Investigation provided by the facility was reviewed regarding the incident between V23 and R6. A typed statement dated 4/13/24 from V21 documents the following: "On 4/13/24, I was assigned as floor nurse on 200 hall. I started work at 1530 (3:30PM). Began passing meds (medications) around 1600 (4:00 PM). Around 1615 (4:15 PM) V12 approached me at the med (medication) cart and stated I need to tell you something about V23 when we get to the dining room. I stated okay and passed the medication. V12 stated that while V23 and I were getting R6 up for dinner, he was screaming and V23 held his shirt over his mouth and said, 'you stop and I'll stop. Then we got R6 transferred into his wheelchair, he began screaming again and V23 took R6's pants and again put it over his mouth and stated, you stop and I'll stop. I (V21) immediately locked my medication cart and went to find V23 and asked her to speak with me. V23 admitted that she did indeed hold his shirt, and then his pants over his mouth in an effort to get him to stop screaming, and then stated, well it wasn't covering his nose. I (V21) replied in question do we cover our resident's mouths in order to quiet or console them? She (V23) replied well, I have before. I (V21) questioned her stating

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do you understand this is abuse and you legally cannot do that? she (V23) stated she hadn't done it at this facility before today. I (V21) replied we are going to have to ask you to clock out and leave the facility, I am required to report this to V1, our administrator and she will be in contact with you if she needs anything further. She (V23) stated I will call V1 myself. I (V21) stated that is fine, but I am still required to contact her myself. V23 left the facility with no issues."

2. R2's admission record documents an admission date of 1/15/21. This same document has a date of birth as 6/25/33 and includes the following diagnoses: Acute Respiratory Failure, Major Depressive Disorder, and vascular dementia.

R2's 4/4/24 MDS Section C documents a BIMS of 3 indicating a cognitive impairment.

On 5/7/24 at 1:05PM, V10 (CNA) stated that she was working the day the incident occurred when R5 wandered into R2's room. When R2 told him to leave he mumbled something and shoved R2 which caused her to stumble and fall hitting her back on the bed. V10 stated that she witnessed R2 stumble and fall on her bottom but did not hit her head. V10 went on to state that R2 does not remember the incident and has not had any behavioral concerns resulting from this happening to her, nor has she had any lasting effects. V10 stated that she was assessed immediately.

Nursing progress note from 5/3/2024 by V29 (LPN) documents R5 entered R2's room and R2 stood up and told R5 to get out and R5 shoved her in the chest causing R2 to fall. R2 landed on her bottom. R2 hit her mid back on the side rail of the bed but did not hit her head. V29 notified POA (Power of Attorney) and physician. No new orders at this time due to no injury noted.

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On 5/7/24 at 10:26 AM, V1 stated that she substantiated the resident-to-resident abuse between R5 to R2. V1 stated that the police, the emergency contact and the physician were all notified and that R2 did not sustain any injuries from the physical abuse. V1 stated that R5 has had behaviors resulting in her initiating an involuntary discharge in January but could not find a facility that would accept him. V1 stated that after some medication changes his behaviors had slightly diminished so he was allowed to stay longer than expected, but after this incident he was sent to the local emergency room and not allowed to return.

On 5/7/24 at 10:32AM, V25 (Family Member) stated that she was notified that R2 had a fall and that a resident had pushed her (R2) down in her room. V25 stated that she did not sustain any physical injury from this incident but is concerned that R5 would come back to the facility. V25 stated that she had not seen him since the call where she was informed, he wouldn't be returning, but she wanted to make sure. V25 stated that she felt he was unsafe to be around these elderly confused residents and is worried for her aunt and all the other resident's safety.

On 5/7/24 at 1:30PM, R2 was attempted to be interviewed regarding the incident. However, due to cognitive impairment R2 was unable to answer questions appropriately.

The facility policy titled "Abuse Prevention and Prohibition Policy", with a revision date 11/24, documents under the statement of intent, "Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by

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S9999	Continued From page 6 anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals." (B)	S9999		