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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 1/28/25/IL185949	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 3001210b) 300.3210t) 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 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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.

These regulations were not met as evidenced by:

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.

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

Findings include:

R1's Face Sheet documented an Admission Date of 6/29/23 and listed diagnoses including Osteoarthritis and Alzheimer's Disease. R1's Minimum Data Set (MDS) dated 12/9/24 documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 has severe impaired cognition.

R2's Face Sheet documented an Admission Date of 9/17/24 and listed diagnoses including Diabetes Type 2 and End Stage Renal Disease Dependent on Dialysis. R2's MDS dated 12/26/24 documented a BIMS score of 14, indicating R2 is cognitively intact.

R2's Nursing Progress Notes, authored by V9, Licensed Practical Nurse, documented the following:
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."
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."
1/11/25 at 2:27pm: "(R2) started to propel self to female patient again by common area. I told (R2)

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

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."

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."

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.

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

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

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.

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.

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

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

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.

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."

R2's Progress Notes also document the following:
1/30/25 at 4:00pm, authored by V9: "Following female residents around. CNA's helped him into recliner to rest."
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."

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

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

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.

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.

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."

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

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.

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."

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.

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

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 02/18/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

happened." R2 denied touching any peers inappropriately, nor any peers touching him inappropriately.

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."

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."

(B)