STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145456	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health & Rehab Center	1200 University Avenue Carlinville, IL 62626

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to identify resident specific behaviors and develop a behavioral care plan with individualized interventions for residents with behavioral health needs for 3 of 6 residents (R2, R3, R8) reviewed for behavioral health services in the sample of 10. Findings include: 1. R2's Face Sheet, undated, documents R2 has diagnoses of Anxiety Disorder and Major Depressive Disorder. R2's Minimum Data Set, MDS, dated [DATE], documents R2 has a BIMS (Brief Interview for Mental Status) score of 14, indicating R2 is cognitively intact. R2's MDS goes on to document that R2 has verbal behaviors directed towards others and rejects care. R2's Care Plan, dated 1/14/25, fails to identify R2's verbal behaviors or rejection of care, therefore no resident specific interventions were implemented. R2's Care Plan does not address R2's diagnoses of Anxiety Disorder and Major Depressive Disorder or interventions to address this. R2's Progress Note, dated 2/8/25 at 8:39 AM, documents the following: After eating breakfast resident attempted to incite a riot about cigarette smoking was trying to encourage all residents on his hall that smoke to get cigarettes to go smoke when that was not effective became verbal aggressive stating that he was leaving and going home AMA (against medical advice) required multiple interventions with different approaches. R2's Progress Note, dated 2/10/25 at 5:52 AM, documents the following: Resident c/o (complaining of) feeling depressed & states he's 'going nuts' in his own mind. Mentioned his wife's death and back when he was in the hospital 'clarified brain dead'. He states he would like something for depression. Currently on duloxetine 60 mg (milligrams) daily. Faxed MD (Medical Doctor). (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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Progress Note, dated 2/18/25 at 6:26 PM, documents the following: Resident seen 3 times by writer pacing the Oakdale hall, the third time writer was walking behind him and (R3) as they were rolling back towards the nurse's station and heard them discussing a female resident and checking/ looking into her room to see where she was. Writer informed DON (Director of Nurses) of them lurking the hall for this specific resident. Writer also seen that they were looking/assessing the service doors on that hallway, writer advised that is not an area for residents and they had moved on down the hall as requested. POC (Plan of Care) ongoing. There was no behavior monitoring identified in R2's record that the facility was monitoring for any behaviors. On 3/7/25 at 8:05 AM, V8, Certified Nursing Assistant, CNA, stated R2 would follow around female residents and staff and make inappropriate comments to them. V8 stated one time, R2 told her he was going to take her out to Ponderosa and grope her. V8 stated it was reported to management and the female staff were not allowed to provide care to R2 without another staff member present, including during smoke times, there would have to be two staff present. V8 stated she isn't sure if they talked to R2 about his behaviors. 2. R3's Face Sheet, undated, documents R3 has a diagnosis of Anxiety Disorder. R3's CHIRP (Criminal History Report, dated 2/21/25, documents R3 has a criminal history with conviction including but not limited to: aggravated criminal sexual assault, aggravated kidnapping, aggravated battery, and unlawful restraint. R3's MDS, dated [DATE], documents R3 has a BIMS score of 15, indicating R3 is cognitively intact. R3's Care Plan, dated 1/7/25, fails to identify resident's diagnosis of Anxiety or any behaviors related to his criminal history, therefore no resident specific interventions were implemented. R3's Progress Note, dated 2/18/25 at 6:31 PM, documents the following: Resident seen 3 times by writer pacing the Oakdale hall, the third time writer was walking behind him and (R2) as they were rolling back towards the nurse's station and heard them discussing a female resident and checking/ looking into her room to see where she was. Writer informed DON of them lurking the hall for this specific resident. Writer also seen that they were looking/assessing the service doors on that hallway, writer advised that is not an area for residents and they had moved on down the hall as requested. POC ongoing. There was no behavior monitoring identified in R3's records that the facility was monitoring for behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 1:00 PM, V6, LPN (Licensed Practical Nurse), stated she observed R2 and R3 on the Oakdale hallway, in their wheelchairs by the service exit, which was unusual for both of them, normally they stayed on their own hallway or was by the exit to go smoke. V6 stated she told R2 and R3 not to go out the service exit door, the alarm would sound, and they would be considered exit seeking. V6 stated she asked both residents to move away from the doors and both did and as they were propelling themselves down the hallway, they stopped in front of R10's door and were peeping in, asking each other where R10 was. V6 stated R10 was in her room, in bed with the lights off sleeping and she didn't think it was appropriate that they were outside her room looking in on her, so she asked them what they were doing and R3 stumbled on his words but said they weren't doing anything so V6 asked them to move away from R10's room and both complied and left R10's hallway and went to the nurse's station and didn't return down that hallway or to R10's room. V6 stated that R2 and R3 were aware that R10 had a relative that worked at the facility and felt as though R10 got special treatment with smoking and was allowed to go out more often. V6 stated all residents were required to follow the smoking policy including R10. V6 stated on that particular day, it was below 30 degrees outside so facility management had made the decision not to allow the residents to go out and smoke, and she feels that they didn't see R10 in bed and thought that she had been taken out to smoke. V6 stated that due to R2 and R3's history and R10 being a female, she reported the occurrence and documented it in their charts. V6 stated she hadn't witnessed R2 or R3 being sexually inappropriate with any of the residents. There was an occurrence where she had taken R2 and R10 outside to smoke, it was nice out and she (V4) had made the comment that it was nice outside and couldn't wait for warmer weather and R2 stated that he couldn't wait to take his boat out and would take V6 and she could ride in it with a bikini on. V6 stated she told R2 that she couldn't do that and changed the subject. V6 stated after that she received a friend request from R2 on social media and sent her a message that he had been thinking of her all night long, so she reported it to management, and they tried to keep her from being assigned to R2's hallway. V6 stated if she did have to work on his hallway, she always had another staff member with her during interactions with R2. V6 stated then because R2 and R3 were making sexual comments to other staff, unsure of whom, they initiated cares in pairs and two staff members would go in and assist R2 and R3 together. V6 stated when she did have to care for R2 or R3, she was cordial with them but always had another staff member with her or nearby. V6 stated they had an SSD (Social Services Director) that didn't have full knowledge of that role, so there weren't interventions or safety measures in place to address R2 or R3's behaviors. V6 stated once the facility received the CHIRP results on R2 and R3, they placed them both on one-on-one observation and placed them in a room together at the end of the hallway. On 3/7/25 at 8:00 AM, R10 stated R3 would ask her things, inappropriate things (would not give further details) and it made her feel very uncomfortable. V10 stated she told V2, Director of Nursing, DON. R10 stated she didn't feel that it was abuse, but inappropriate. R10 stated it happened when they would go outside to smoke or sometimes, he would be on her hallway or outside her room and she would tell him to get off of her hallway or away from her room. R10 stated she felt safe in the facility then and now, it just made her very uncomfortable. R10 stated she isn't sure what V2 did after she told her but R3 stopped so she assumes V2 took care of it. R10 stated she hasn't had any further problems like this with the other residents. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/7/25 at 10:20 AM, V1, Administrator, stated staff reported that R2 and R3 were making sexually inappropriate comments to them. They interviewed all the female residents and neither R2 nor R3 were making those comments to them, only the female staff. V1 stated they placed R2 and R3 on one-on-one observation and moved them into a room together until they discharged from the facility. V1 stated R10 had reported to V2, DON, who is also R10's daughter, that R2 and R3 would ask R10 to talk V2 into letting them go out to smoke at times other than on the smoke schedule or when it was too cold. V1 stated if a resident has behaviors, it will be documented on their care plan and the progress notes with interventions specific to their behaviors in the care plan. 3. R8's Face Sheet, undated, documents R8 has diagnoses of Dementia and PTSD (Post Traumatic Stress Disorder). R8's CHIRP, dated 10/22/24, documents R8 has a criminal history with conviction of criminal sexual assault and is an identified sex offender. R8's MDS, dated [DATE], has a BIMS score of 3, indicating R2 has severe cognitive impairment. R8's Care Plan, dated 10/22/24, fails to identify resident specific interventions related to his diagnosis of PTSD and R8's criminal history. R8's Behavior Monitoring, dated 2/20/25, fails to identify resident specific behaviors or interventions. R8's Progress Note, dated 12/16/24 at 12:03 PM, documents the following: Social Service Note - Attended phone meeting today with State of Illinois referred psychiatrist. Dr. (doctor) stated that (R8) will now be considered very low risk and the only recommendations he will have is that (R8) will not be allowed to be unsupervised with minors while in the facility. R8's Progress Note, dated 1/21/25 at 11:50 AM, documents the following: Received notes from NP (Nurse Practitioner) to add dx (diagnosis) of PTSD to chart and start Sertraline 50 mg PO (by mouth) Q HS (every bedtime) from recent visit on 1/17/25. Resident is own person and made aware of orders. R8's Progress Note, dated 2/2/2025 at 6:00 AM, documents the following: Reminders needed to stay out of lady resident's rooms. Had to be redirected during night x 2 back to his room. On 3/6/25 at 8:40 AM, V3, Wound Nurse, stated they do have identified offenders including one sex offender, R8. V3 stated R8 does have dementia and hasn't displayed any sexual behaviors towards the staff or other residents. V3 stated any resident with behaviors have interventions in place and they can be found on their behavior care plan. The Behavioral Health Services Policy, dated 7/1/23, documents the facility will provide and the residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The Behavior Monitoring Policy, dated 10/3/20, documents the facility will ensure residents experiencing behaviors are monitored and interventions are appropriate to attain or maintain the highest practicable physical, mental, and psychosocial well-being.