

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Lakeside Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, monitor, and provide interventions to prevent decannulation for a resident with known behaviors of self-decannulation; and failed to ensure that staff were provided tracheostomy recannulation education for extubation for 1 of 2 residents (R3) reviewed for tracheostomy in the sample of 2. The failure resulted in R3's self-decannulation of her tracheostomy which compromised R3's health status. R3 required emergency transfer to the local hospital on [DATE] and required two attempts at reinsertion of the tracheostomy and arterial line placement. After reinsertion of R3's tracheostomy by an ENT physician, R3 became hypoxic with oxygen saturation in the 80's and had increased work for breathing. R3's hospital records document R3 ultimately died on [DATE] with clinical impression of tracheostomy complications, cardiopulmonary arrest and heart block. R3's death certificate is pending investigation. This failure has the potential to affect all residents with tracheostomy medical needs. The Immediate Jeopardy began on [DATE], when R3 was admitted to the facility with a tracheostomy tube. R3's Infectious Disease Progress Note dated [DATE] documents R3 had a history of tracheostomy tube decannulation prior to being admitted to the facility. R3's care plan dated [DATE] had no documented interventions to prevent R3 from self-decannulating tracheostomy tube. R3 self-decannulated her tracheostomy tube at the facility on [DATE] and she was transferred to the emergency room and readmitted to the facility the same day. No interventions were added to R3's care plan to prevent her from decannulating the tracheostomy again. On [DATE] staff documented R3 removed her tracheostomy again and was transferred to the emergency room. R3's clinical impressions included tracheostomy complications, cardiopulmonary arrest and heart block. On [DATE] at 9:26 AM PM V1, Administrator, V2 DON and V28 Regional Nurse were notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview and record review, the Immediate Jeopardy was removed on [DATE], but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R3's Infectious Disease Physician Progress Note, dated [DATE] documents R3 pulled out her tracheostomy tube 3 weeks prior. On [DATE] at 2:00 PM V2, DON provided a timeline of R3's health status. The timeline documented R3 had a history of decannulating her tracheostomy tube prior to being admitted to the facility. R3's Undated Face Sheet documents she was initially admitted on [DATE] with diagnoses including acute respiratory failure with hypoxia, tracheostomy, pneumonia, colostomy, gastrostomy and high blood pressure. R3's admission Nurse Assessment, dated [DATE] documents reason for admission: pneumonia, peg-tube and IV (intravenous) ABT (antibiotics.) No behaviors documented. No documentation R3 had a tracheostomy tube upon admission. R3's Physician's Order Sheet (POS), dated [DATE] documents oxygen humidified at 6 LPM via trach collar continuous two times a day for shortness of breath. R3's Comprehensive Care Plan, dated [DATE] documents R3 has the presence of a tracheostomy at this time r/t (related to) DX (diagnosis) of acute respiratory failure. Goal: R3 will have no complications r/t tracheostomy through next review date. Interventions: all orders r/t tracheostomy will be followed, and MD (physician) updated with any concerns. No documentation of interventions to prevent R3 from decannulating her tracheostomy tube. R3's Nurse Progress Notes dated [DATE] through [DATE] no documentation R3 was agitated, restless or behaviors of pulling on tracheostomy tube or collar. R3's admission Minimum Data Set (MDS) dated [DATE] documents R3 is cognitively impaired, had no behaviors exhibited, a tracheostomy and a diagnosis of respiratory failure. R3's Nurse Progress Note dated [DATE] documents at 6:19 AM, writer entered resident's room at 5:15 AM to administer morning medication and discovered trach dislodged. R3 was transferred to the emergency room. R3's Health Status Note, dated [DATE] at 5:15 PM, documents resident returned to facility from the ER (emergency room) following a trach tube replacement. Trach was replaced due to dislodgement. R3's Comprehensive Care Plan has no documentation of interventions to prevent R3 from decannulating her tracheostomy tube after removing it on [DATE] documented. R3's form dated [DATE] through [DATE] documents follow up question: Did resident display change in mood? [DATE] through [DATE] documents No change. [DATE] at 2:02 PM, Other documented. R3's Health Status Notes, dated [DATE] through [DATE], no documentation of R3 being agitated, restless or having behaviors of pulling on tracheostomy tube. R3's Nurse Progress Note dated [DATE] at 1:25 PM V12, RN documented Res noted to be restless and pulled bag off colostomy and trach out. MD notified and orders to send to ER, POA notified. R3's Emergency Medical Services (EMS) Run Report, dated [DATE] documents the primary</p>		