

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 11/13/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a safe transfer for 1 of 1 resident (R6) reviewed for accidents in the sample of 16. Findings include:R6's admission Record, print date of 10/2/25, documents R6 was admitted on [DATE] and has diagnoses of Alzheimer and Dementia.R6's Minimum Data Set, dated [DATE], documents R6 is severely cognitively impaired, uses wheelchair, is dependent on staff for toileting, showers, lower body dressing, personal hygiene, and all mobility except rolling in bed.R6's Care Plan, dated 12/12/23, documents, (R6) has a Self-Care Deficit As Evidenced by: Needs assistance with ADLs (Activities of Daily Living) related to dx (diagnosis): ALZHEIMER'S DISEASE, UNSPECIFIED, HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE. Intervention: Transfer: Two person physical assistance required Date Initiated: 12/13/2024.R6's Therapy to Nursing Recommendations, dated 8/21/25, documents R6 transfers with assist of 2 with a wheeled walker.R6's Health Status Note, dated 9/3/2025 08:53, documents, Residents daughter/POA (Power of Attorney) (V16) approached nurses station to report that resident had redness discoloration/bruising noted to the top of both hands this AM and a small skin tear present to the top of her left hand. Upon assessment this nurse noted that resident does have reddish discoloration/bruising present to the top of both hands and wrist area. ROM (range of motion) appears to be unaffected, and resident denies pain/ discomfort at this time. Does have a small skin tear present to the top of her left hand with absence of any drainage or discharge from open area. MD (Medical Doctor), DON (Director of Nurses) and Administrator notified of incident. Skin tear cleaned with wound cleanser and steri-strips applied as ordered.R6's Health Status Note, dated 9/3/25, documents, Made (V17) office aware of skin tear and reddish discoloration/bruising to bilateral hand and wrist. Made aware of skin tear to top of left hand and treatment started.R6's Health Status Note, dated 9/6/24, documents, Discoloration continues to bilateral wrists, s/sx (signs and symptoms) of tenderness noted to discoloration. Two steri strips to left hand intact, no s/sx infection noted. Resident continues scheduled tylenol.R6's Health Status Note, dated 9/7/25, documents, Discoloration continues to bilateral wrists, no s/sx of tenderness noted to discoloration. Two steri strips to left hand intact, no s/sx infection noted. Resident continues scheduled tylenol.R6's Health Status Note, dated 9/7/25, documents, Discoloration continues to bilateral wrists, no s/sx of tenderness noted to discoloration. Two steri strips to left hand intact, no s/sx infection noted. Resident continues scheduled tylenol.R6's Health Status Note, dated 9/8/25, documents, Discoloration continues to bilateral wrists, no s/sx of tenderness noted to discoloration. Two steri strips to left hand intact, no s/sx infection noted. Resident continues scheduled tylenol.R6's Health Status Note, dated 9/20/25, documents, Bruises to Lt (left) wrist and arm are resolved. continue monitoring Rt (right) wrist and arm.R6's QA (quality assurance) report, dated 9/3/25, documents, General Information Type: Skin Issue. Incident Location unknown Prior caregiver (V18, Certified Nurse Aide (CNA)), other treatments: steri strips and wound cleanse to top of left hand. Details: Skin Issue Type Bruise. Wound Description Base Color red Wound description: resident has reddish bruising / discoloration noted to bilateral hands with small skin tear present on top of left hand. Injuries Type Bruise Location Left Hand Date / Time 9/3/25 7:00 AM Details red discoloration / bruising noted with small skin tear on top of left hand. Bruise location Right Hand Date / Time 9/3/25 7:00 AM Details red bruising / discoloration present to top of hand. Investigate. Conclusion: investigation reveals that CNA likely transferred the resident with one instead of 2. CNA denies. CNA working her last shift at (facility) on this day and no longer works her. Marked in her file that she is ineligible for re-hire.On 9/29/25 at 3:13 PM, V19, R16's Husband, stated he comes every day and sits with R6 all day. He stated that when he came in this morning R6's elbow was bleeding a little bit, and he let the facility know. He said she must have bumped it. V19 was questioned if he had concerns about abuse or R6's safety, V19 stated no but about a month ago both of her wrists were bruised it looked like she was pulled. I am not sure what they did about that.On 10/2/25 at 9:29 AM, V2, Director of Nurses, stated I did do an investigation into R6's hands. I determined the CNA V18 transferred R6 by herself. R6 requires 2 staff members and a gait belt for a safe transfer. This happened on V18's last night shift. She had already turned in her notice of quitting. The bruising was reported to me at 7:00 AM after V18 had already clocked out and went home. I let V16 know that it V18 did not work her anymore because when she clocked out at 6:00 AM her employment was finished.On 10/2/25 at 10:45 AM, V6, CNA, stated R6 transfers with 2 staff members and a gait belt.On 10/2/25 at 1:05 PM, V20, Licensed Practical Nurse, stated I was told about R6's wrists and hands. They were just kind of red, the left had a skin tear, and I think the right</p>		