| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145456 | A. Building<br>B. Wing | 04/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lakeside Health & Rehab Center | 1200 University Avenue<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review, the facility failed to report a fall timely, follow fall incident procedures, and use gait belts during transfers for 3 of 5 residents (R1, R2, R3); reviewed for Quality of Care in a sample of 6. This failure resulted in R2 being moved before a nurse's assessment and delayed treatment for that R2 succumbed multiple pelvic fractures from later requiring surgery. Findings include:1.R2's Facesheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, atrial fibrillation, anemia, and age-related osteoporosis prior to her fall.R2's Minimum Data Set (MDS) dated [DATE] documented R2 was cognitively intact and required substantial/maximal assistance for toilet transfers and going from sitting to standing.Care Plan initiated 1/14/26 documented R2 was at risk for falls and included the following intervention, in part, for staff to encourage call light usage.R2's Fall Incident Investigation documented her fall occurred on 2/10/26 at 9:00 AM. The investigation included a Corrective Action/Termination Form dated 2/11/26 that documented V8 Certified Nursing Assistant (CNA) received a final warning for not following safety procedures and unsatisfactory job performance. The Corrective Action Form documented details of the incident included R2 reported to V8 that she had fallen and V8 stated I won't tell if you don't. V8 didn't report the fall to the nurse until after R2 began complaints of pain. R2's Incident Report dated 2/10/26 documented that she fell and was sent out by ambulance to the hospital at 10:40 AM with injuries to pelvis that included a reddened area on right side upon initial assessment. The report continued to document R2 stated, I fell when I tried to get up and transfer myself and I told the CNA I did not want him to tell anyone that I fell because I am fine and my family is dealing with enough right now. R2's Progress Note dated 2/10/26 at 2:17 PM documented V20 (Prior Director of Nursing/DON) stated, Writer was notified that resident had experienced a fall in her bathroom when transferring without assistance leading to R hip pain. Upon assessment area appears slightly red. Resident states that it hurts to move her right leg or put weight on her right leg. Granddaughter at bedside upon this RN entering room.R2's Hospital Records dated 2/10/26 documented R2 was diagnosed with minimally displaced fractures involving the right superior and inferior pubic rami from falling.R2's Orthopedic Clinic notes dated 2/13/26 documented R2 had 2 (possible 3) pelvic fractures. The notes continued to document recommendation of surgery for an implant in the pelvis to stabilize her pelvic fractures. R2's Hospital Records dated 2/19/26-2/25/26 documented R2 was hospitalized for her pelvic fracture.On 4/13/26 at 10:20 AM, R2 stated she was helped to the restroom the day she fell by a male CNA and told to pull the string when she was done. R2 stated she waited for a while and no one came so she wasn't sure if she was supposed to pull it and go back to bed or just wait. R2 stated the CNA didn't tell her not to get up and she didn't know what to do. R2 stated while she was waiting, she started to get uncomfortable and having pain so she deciding to get up herself and she made it just right outside the bathroom door when she fell. R2 stated the male CNA found her and helped her back to bed but what really bothered her was that he told her not to tell anybody what happened. R2 stated she thinks he wasn't supposed to leave her alone on the toilet and got scared maybe. R2 stated she doesn't blame the CNA though, they are so understaffed. R2 stated she ended<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | up going to the hospital with pelvic fractures and required surgery to correct it. R2 stated it's been a rough recovery and has been getting therapy and they say it's one of the most painful breaks to deal with. R2 was sitting in her wheelchair, her call light was not in reach. R2 stated when the CNA came to tell her she would be back to help her shower earlier, she left her call light somewhere and couldn't find it; she didn't make sure I had it before she left. R2's call light was buried under sheets in her bed on the opposite side of where R2 was sitting in her wheelchair.On 4/13/26 at 9:09 AM, V4 (R2's Family) stated R2 told her that she was taken to the bathroom by staff and left. V4 stated at the time of her fall R2 wasn't doing anything on her own, needed help with transfers. V4 stated R2 told her she waited for staff to come back to help her off the toilet for a long time and was starting to have pain in her back, so she decided to get up herself and fell. V4 stated R2 told her the male CNA found her on the ground and told her not to tell anyone, and he didn't report it. V4 stated V9 (R2's Family) visited R2 later that morning and that's when R2 told V9 she had fallen, and she was in pain. V4 stated V9 told the nurse who didn't know anything and then the DON overheard it all and came to assess. V4 stated V9 told her the DON sent her to the hospital to be assessed and that's when she was notified. V4 stated R2 sustained 3 pelvic fractures and later required surgery to correct. On 4/13/26 at 12:14 PM, V8 (CNA) stated he found R2 on the floor when he was walking by her room that morning, no call light was going off and the last time he saw her was in the dining room for breakfast. V8 stated R2 is able to wheel herself around independently. V8 stated he went to help R2 and she wanted him to help her up but not to tell anyone because she was doing so good in therapy, so he did that. V8 stated at the time R2 was a pivot and one assist for transfers. V8 stated R2 did not use her call light to get help at that time. V8 stated he was the only CNA working that hall at the time. V8 stated he was not trying to neglect her in any way; she was laughing and didn't complain of pain at the time. V8 stated when R2 pressed her call light about an hour later though she told him she was in pain and that's when he decided to report it to the nurse. V8 stated R2 was usually really good about using her call light prior to her fall and was known to use it. V8 stated R2 told him she felt silly it happened.On 4/13/26 at 1:41 PM, V9 (R2's Family) stated she came to visit R2 around 10:00 AM that morning and she was lying in bed. V9 stated she asked how R2 was doing, and she told her not good, she had a fall after using the toilet. V9 stated R2 told her she waited for a long time and decided to get up herself then fell. V9 stated R2 told her that the CNA told her not to tell anyone, and she didn't until she saw me. V9 stated she told the nurse who knew nothing about a fall and the DON came over to find out what happened. V9 stated R2 was in a lot of pain when she got there. V9 stated R2 didn't want the CNA to get in trouble. V9 stated R2 had had falls at home and would use her call light for assistance but it wouldn't surprise her if she sometimes doesn't.On 4/13/26 at 2:00 PM, R2 stated she was in a lot of pain when she fell, it was at least a ten out of ten on a pain scale and she was crying when the CNA found her.On 4/14/26 at 10:49 AM, V15 Licensed Practical Nurse (LPN) stated she was R2's nurse the day she fell. V15 stated she was first notified by V8 (CNA) that she had fallen. V15 stated she couldn't remember if V8 stated he had gotten R2 up already or not. V15 stated she immediately told V20 (Prior Administrator) to go look at R2 since she had pills out on her cart. V15 stated she did not go see R2 right away but later did see her in her bed.On 4/14/26 at 12:47 PM, V19 (Medical Director) stated he expects a fall to be reported at the time it occurs and the resident should not be moved ideally before a nurse assesses them in case of head or neck injury. V19 stated R2 did have fractures and required surgery. V19 stated he does not consider R2 was neglected. V19 stated he expects staff to be following the facility's Incident/Accident Policy.2.R1's Facesheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, dementia, type two diabetes mellitus, and heart failure.R1's MDS dated [DATE] documented R1 was cognitively intact. R1's Care Plan dated 4/3/24 documented she was at risk for falls and injuries. R2's fall care plan included the following interventions, in part, observe for unsteady gait and balance on 4/3/24.Facility incident reports documented R1 fell 3/7/26, 3/11/26, two times on 4/6/26, and on 4/13/26.R1's Fall Risk assessment dated [DATE] documented she was at high risk for falls, having three or more falls in the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | past three months and requires assistive devices for gait/balance.On 4/13/26 at 9:51 AM, V5 (CNA) stated she was going to assist R1 to the restroom, she's a standby assist and has had a couple falls lately. V5 placed R1's walker in front of her while she sat in her wheelchair and stood by to assist her without applying a gait belt. R1 walked with her walker to the restroom, was unsteady throughout the process but corrected herself as she walked very slowly. V5 assisted R1 with pulling her brief down at the toilet, R1 stood without her hands holding anything for several seconds before finally using her right hand to grab the side bar on the wall next to the toilet and lowering herself down.3.R3's Facesheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, surgical aftercare following surgery on the digestive system, hypertension, and atrial fibrillation. R3's MDS dated [DATE] documented she was moderately cognitively impaired and was not assessed for toileting transfers or sit to stand transfers due to health conditions or safety concerns.R3's Care Plan dated 1/28/26 documented she was at risk for falls and injuries.On 4/13/26 at 9:58 AM, R3's call light was lighting up red and was sitting in her wheelchair waiting in the bathroom for assistance to use the toilet. At 10:10 AM, V5 (CNA) entered R3's room. V5 brought R3 outside of the bathroom and put her walker in front of her, then assisted her to a standing position by holding the back of her pants (did not apply a gait belt) the entire way to the toilet.On 4/13/26 at 8:21 AM, in a joint interview with V16 Certified Occupational Therapy Assistant (COTA) and V17 (COTA) both stated a transfer with one assist should have a gait belt used. Both stated R1 and R3 should have had a gait belt used during their transfers. V16 stated recently R1 had a decline, and she was independent but now is not and that is why we picked her up in therapy. V17 stated R3 is a one assist and a gait belt should have been used. V17 stated we will educate the staff today on transfers. On 4/14/26 at 10:49 AM, V15 (LPN) stated a gait belt should absolutely be used if indicated. V15 stated call lights should be left in reach for safety measures. V15 stated falls should be reported immediately and residents should not be moved until the nurse has assessed them in case they have injuries.On 4/14/26 at 11:55 AM, V1 stated V5 (CNA) is the lead CNA at the facility. V1 stated falls are to be reported immediately to the nurse and residents not to be moved before the nurse assesses them to prevent further injury. V1 stated she would absolutely expect gait belts to be used during transfers. V1 stated call lights should be left in reach at all times for residents to be able to alert staff for need of assistance. V1 stated she is not aware of any neglect or reports of neglect at this time. V1 stated V8 definitely did not have good intentions, it was definitely a delay in treatment though.On 4/14/26 at 12:00 PM, V2 (DON) stated she expects falls to be reported immediately, and the resident is not to be moved prior to a nurse assessing them to make sure it's safe to move them. V2 stated she expects gait belts to be used when indicated. V2 stated V8 (CNA) should not have moved R2 at all after she fell, that's not okay in any way.The facility's Accidents and Incidents policy dated 7/1/23 documented accidents and incidents, including injuries of an unknown origin, must be reported to the department supervisor, and an Accident/ Incident Report should be completed on the shift that the accident or incident occurred. The policy continued to document, Render immediate assistance. DO NOT move the victim until he/she has been examined for possible injuries. If assistance is needed, summon help. If you cannot leave the victim, ask someone to report to the nurse's station that help is needed, or if possible, use the call system located in the resident's room to summon help.The facility's Transfer policy dated 7/1/23 documented gait belts, full body mechanical lifts, and/or sit to stand/partial body mechanical lifts will be used, unless otherwise specified and it is the responsibility of all nursing staff to ensure the use of safe transfer techniques when transferring a resident. The policy continued to document the transfer technique used for the resident will be evaluated and determined by the nurse or directed by therapy. |