

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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 03/28/2025
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility opened a package belonging to a resident without their permission for 1 of 3 residents (R2) reviewed for Communication with Privacy in the sample of 31. Findings include: On 3/25/25 at 9:35 AM, R2 stated he had ordered a wireless charger and when it came, staff (unknown) opened the package prior to giving it to him without his permission because they thought it was medication. R2 stated he tells the staff when he has ordered something, so they don't open it and he does not order his medication anymore, the facility does. R2's Minimum Data Set, dated [DATE], documents R2 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R2 is cognitively intact. R2's Admission Contract, dated 12/20/24, documents R2 declined authorization for the facility to inspect and open official correspondence. On 3/26/25 at 8:58 AM, V1, Administrator, stated V1 the resident's mail/packages are not opened by staff. On 3/26/25 at 3:21 PM, V2, Director of Nurses, stated they do not have a policy on resident mail.		

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the Facility failed to report an injury of unknown origin for 1 of 1 resident (R265) reviewed for abuse in the sample of 31. Findings include: R265's Face Sheet documents R265 was admitted to the facility on [DATE] with diagnoses including unspecified dementia and metabolic encephalopathy. R265's Minimum Data Set (MDS) dated [DATE] documented R265 was severely cognitively impaired and dependent with mobility. R265's Care Plan does not address risk of abuse and neglect. R265's Weekly Skin Inspection dated 3/13/25 did not document any skin impairments. R265's Progress Note by V15, Registered Nurse (RN), on 3/14/25 at 11:45 AM documents, At 11:30 a.m. activities personnel brought resident to the nurse's station and showed this nurse a skin tear to resident's right arm. Skin tear 5 cm (centimeters) x 3 cm x 0 cm noted to resident's right arm. Resident unable to explain how she sustained the skin tear. R265's Progress Note by V15 on 3/14/25 at 2:16 PM documents, New order per (V17, Medical Director): Monitor (sterile strips), applied TAO (triple antibiotic ointment), non adherent pad, wrap with (cotton gauze bandage), secure with paper tape. On 3/26/25 at 11:28 AM, V15 stated R265 got a skin tear on 3/14/25 and could not tell me how she got it. On 3/27/25 at 12:30 PM, V16, CNA, stated he took R265 to the dining room, and she did not have a skin tear at that time. Soon after that, R265 was at the nurse's station with a skin tear. V16 does not know how it happened. On 3/26/25 at 11:00 AM, V14, Activities Assistant, stated she noticed R265 was bleeding when she came down to the dining room, so she took her back to her nurse. V14 did not know how the injury occurred. On 3/26/25 at 12:52 PM, R265 was sitting in wheelchair in her room with two bandages on her right forearm. R265 was unable to explain what happened to her arm. On 3/26/25 at 10:50 AM, V2, Director of Nursing (DON), stated the skin tear was not reported to IDPH. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Abuse Policy revised 1/9/24 documents, The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff responsibility to report any allegation or witnessed abuse Immediately to the Administrator (Abuse Coordinator). The facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities to include IDPH, Ombudsman, Local P.D. (Police Department), POA (Power of Attorney), M.D. (Medical Doctor) in a timely manner.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview and record review, the Facility failed to investigate an injury of unknown origin in a timely manner for 1 of 1 resident (R265) reviewed for abuse in the sample of 31. Findings include: R265's Face Sheet documents R265 was admitted to the facility on [DATE] with diagnoses including unspecified dementia and metabolic encephalopathy. R265's Minimum Data Set (MDS) dated [DATE] documented R265 was severely cognitively impaired and dependent with mobility. R265's Care Plan does not address risk of abuse and neglect. R265's Weekly Skin Inspection dated 3/13/25 did not document any skin impairments. R265's Progress Note by V15, Registered Nurse (RN), on 3/14/25 at 11:45 AM documents, At 11:30 a.m. activities personnel brought resident to the nurse's station and showed this nurse a skin tear to resident's right arm. Skin tear 5 cm (centimeters) x 3 cm x 0 cm noted to resident's right arm. Resident unable to explain how she sustained the skin tear. R265's Progress Note by V15 on 3/14/25 at 2:16 PM documents, New order per (V17, Medical Director): Monitor (sterile strips), applied TAO (triple antibiotic ointment), non adherent pad, wrap with (cotton gauze bandage), secure with paper tape. On 3/26/25 at 10:50 AM, V2, Director of Nursing (DON), provided an undated investigation documenting, On 3/14/25 (R265) had a skin tear on right forearm. Upon talking to the activity assistant, the CNA (Certified Nursing Assistant) had brought resident down from activities and she noticed a skin tear to right arm. She brought resident back to the nurse's station for it to be addressed. Speaking with nurse (V5) Resident was wheeling self to (room) and was close to the guard rail. It is believed that she bumped her arm off of the guard rail on Rosemont hallway due to blood being noted on the side rail. The document was signed by V3, Licensed Practical Nurse (LPN), and documents V5, LPN, V14, Activities Assistant, and V16, CNA, were interviewed. On 3/26/25 at 10:55 AM, V5 stated she was not R265's nurse on 3/14/25 but remembers hearing about R265 sustaining a skin tear on her arm. She did not see R265's arm or the handrail that day. On 3/27/25 at 12:30 PM, V16 stated he took R265 to get weighed, then he took her to the dining room. She did not have a skin tear at that time. Soon after that, she was sitting at the nurse's station with a skin tear. V16 stated he did not know how it happened and did not see any blood on the railing, and V3 just called to ask him about it one day this week. On 3/26/25 at 11:00 AM, V14, Activities Assistant, stated she noticed R265 was bleeding when she came down to the dining room, so she took her back to her nurse. V14 did not know how it happened and was not interviewed about it until V3 asked her about it today. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25 at 11:28 AM, V15, Registered Nurse (RN), stated she remembers the Activities person bringing R265 down to her and saying she had a skin tear. R265 could not tell me how she got it, and V15 did not see the handrail in question. On 3/26/25 at 12:52 PM, R265 was sitting in wheelchair in her room with two thin bandages on her right forearm. She was unable to explain what happened to her arm. On 3/26/25 at 11:03 AM, V3 stated she just began the investigation today and did not interview R265's nurse from 3/14/25. The Facility's Abuse Policy revised 1/9/24 documents, The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff responsibility report any allegation or witnessed abuse Immediately to the Administrator (Abuse Coordinator). The facility immediately and thoroughly investigates all allegations of abuse to include by not limited to interview or residents and staff, visitors, Vendors.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834 Based on Observation, Interview, and Record Review the facility failed to implement preventative measures to reduce the development of and worsening of pressure injuries in 2 of 7(R55, R39) residents in the sample of 31. This failure resulted in R55's skin on 1/7/25 documented as mid buttocks maceration to a developed and documented sacrum pressure ulcer stage 3 on 1/16/25; and other in house developed pressure wounds. R39 also developed several in-house pressure injuries. Findings include: 1. R55's Face sheet documents an admitted [DATE]. Diagnosis include Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Dysphagia, Type 2 Diabetes, Congestive Heart Failure. R55's Minimum Data Set, MDS, dated [DATE] documents R55 is moderately cognitively impaired. R55 is dependent for rolling left to right and chair to bed transfers. R55 is at risk for pressure injuries and has unhealed pressure injuries. R55's care plan updated 3/4/2025 documents Actual Pressure Ulcer; Site(s): unstageable of sacrum. Requires assist with turning and positioning, present on admission. Provide off loading for ulcer site. R55 has an arterial ulcer of the right lateral ankle, arterial of right lateral foot. Heels up device as tolerated in bed. R55's admission nursing assessment dated [DATE] documents mid buttocks maceration. R55's Braden Scale for predicting pressure sore risk documents R55 is at moderate risk of developing pressure ulcers. R55's progress notes dated 1/7/2025 at 6:25PM documents Skin is unremarkable but there is maceration to buttocks, zinc is ordered for this. R55's wound notes dated 1/16/2025 documents sacrum pressure ulcer stage 3. Measurements 6.5 cm x 1.5 cm x .10cm. R55's wound notes dated 1/23/2025 documents Sacrum unstageable pressure wound. Measurements 5.5 cm x 1.2 cm x .20 cm. New in-house facility acquired right lateral ankle wound. Measurements 2cm x 1.5cm x .10cm. R55's wound notes dated 2/13/2025 documents Sacrum pressure wound stage 3. Measurements 2 cm x .8 cm x .2 cm. Right lateral ankle arterial ulcer full thickness 2.5 cm x 2.5 cm x .10cm. New facility acquired right lateral foot. Measurements .70 cm x .50cm. R55's wound notes dated 3/20/2025 documents sacrum pressure wound stage 3. Measurements 1.5 cm x .7 cm x .7 cm. Right lateral foot new facility acquired. Measurements 1.5cm x 1cm x .10cm. Right lateral ankle arterial ulcer full thickness 3.5 cm x 3.3 cm x .3cm. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R55's Skin and Wound note dated 2/27/2025 documents stage 3 pressure injury to the sacrum and an arterial wound to his right lateral ankle and right lateral foot. Patient was placed on PO Augmentin by PCP for his right lateral ankle, he had a wound culture after he finished this antibiotic, and it was positive for MRSA. He was placed on doxycycline and finished this antibiotic 1-2 days ago per wound nurse. Preventative Measures: R55 has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. Float heels while in bed with use of heel boots. On 3/27/2025 at 10:45AM R55 lying flat in bed. No heel protectors on in bed. Heels to the mattress. On 3/27/2025 at 12:15PM R55 up in geriatric chair sitting straight up with feet directly on bottom of chair. Heels not floated. On 3/27/2025 at 3:15PM R55 remains up in geriatric chair with feet to bottom of chair. Heels not floated. On 3/27/2025 at 10:30AM V3, Wound Nurse, stated when R55 came to us the Nurse Practitioner called the redness to his sacrum maceration. The wound kind of deteriorated into a stage 3. R39's Face sheet documents an admitted [DATE]. Diagnosis includes Encephalopathy, Sepsis, Acute Cystitis, Paroxysmal Atrial Fib, Chronic Kidney Disease, Hyperlipidemia. 2. R39's MDS dated [DATE] documents R39 is severely cognitively impaired and is dependent for bed mobility and transfers. R39 is at risk for pressure ulcers and has unhealed pressure ulcers. R39's care plan dated 2/24/2025 documents Actual Pressure Ulcer; Site(s): unstageable sacrum unstageable Left heel stage 3. Requires assist with turning and repositioning. Interventions include Encourage to Float heels. R39's Braden scale for pressure ulcer development dated 11/26/2024 documents R39 is at risk for pressure ulcer development. R39's Admission assessment dated [DATE] documents wound to left buttock. R39's Skin/Wound visit dated 1/16/2025 at 2:57 PM documents Wound # 1 left heel Pressure ulcer. The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. R39's wound notes dated 1/16/2025 documents new facility acquired wound to left heel. Measurements 3.5cm x 2cm. R39's wound notes dated 1/23/2025 document left heel. Measurements 2.5cm x 2.5cm. R39's wound notes dated 1/30/2025 document left heel. Measurements 3.5cm x 3.0cm. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R39's wound notes dated 2/6/2025 document left heel. Measurements 2.5cm x 3.0cm. R39's wound notes dated 2/20/2025 document sacrum new facility acquired. Measurements 6.5 cm x 7cm x . 10 cm. Left heel 1.5cm x .75cm. R39's wound notes dated 2/27/2025 document sacrum 7cm x 4.5cm. Left heel 1.5cm x .5cm. R39's wound notes dated 3/20/2025 documents sacrum 5.5cm x 4.5cm. R39's order sheet dated 3/17/2025 documents Heel protectors as tolerated two times a day. On 3/26/2025 at 10:00AM R39 lying in bed with no float heels on. Heels on mattress. On 3/27/2025 at 12:55PM V8, CNA, stated R39 is able to roll on side by himself. On 3/27/2025 at 1:00PM V8, CNA, and V20, CNA, provided incontinent care to R39. R39 unable to roll self from left to right or right to left without max assist. Float heels not on. Heels on mattress. On 3/27/2025 at 3:00PM V2, Director of Nursing, DON, stated her expectation is for residents to be turned and repositioned every 2 hours and heels floated as the resident will tolerate. Facility policy with a revision date of 10/16/2023 states Prevention program including Turning and Positioning, will be utilized for all residents who have been identified of being at risk for developing pressure ulcers. The facility will initiate an aggressive treatment program for those residents who have pressure ulcers. A pressure ulcer is defined as any lesion caused by unrelieved pressure those results in damage to underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43794 Based on interview, observation, and record review the facility failed to provide progressive interventions and to prevent multiple falls for 1 of 5 (R47) residents investigated for accidents in a sample of 31. The failure resulted in R47 sustaining a right hip fracture and then sustaining a right hip surgical incision dehiscence requiring a return to the hospital for sutures and antibiotics. Findings include: R47's EMR (Electronic Medical Record) undated documents that the resident was readmitted to the facility after right hip surgery on 12/04/24. R47's EMR dated 4/25/24 documents a diagnosis of unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified osteoarthritis, unspecified site; and age-related osteoporosis without current pathological fracture. R47's MDS (Minimum Data Set) dated 3/11/25 documents a BIMS (Brief Interview for Mental Status) score of 4 out of 15. The MDS documents that the resident requires substantial/maximal assistance for roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer. R47's Care Plan dated 7/25/24 documents (R47) is at potential risk for falls and injuries r/t (related to) use of hypoglycemic medications and diagnosis of Type II DM (Diabetes Mellitus), PVD (Peripheral Vascular Disease), Dementia, Chronic Ischemic Heart Disease, and HTN (Hypertension). R47's Health Status note dated 10/09/24 at 6:58 PM documents Resident had a witnessed noninjury fall at approx. 0830- did not hit head. Vitals 110/62, 69 pulse, 16 resp, 97.4T 96% RA (room air). Resident had c/o (complaint of) of dizziness and pain to LUQ (left upper quadrant) prior to fall. (V17), Medical Director's office notified and POA (Power of Attorney) aware. NNOR (no new order) at this time. No intervention noted for fall on 10/09/24. R47's Health Status Note dated 10/10/24 at 4:08 PM documents Writer called to resident's room by CNA (Certified Nursing Assistant) staff. Resident was observed laying on the floor on the right side of the bed near the door. Floor was dry and free of debris. Resident's legs extended outward. CNA at bedside sitting on floor with resident. CNA (V8) stated I seen (sic) her just roll out of the bed and on to the floor. She didn't hit her head. I just couldn't get to her quick enough to stop her from rolling out of the bed. Resident assessed by writer and assisted to standing position without difficulty. Nursing staff assisted resident back into bed per her request and call light placed in reach. Resident bed was placed in the lowest position and turned towards the wall. Intervention for fall on 10/10/24 is bed to be against the wall. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R47's Health Status note dated 10/17/24 at 2:11 AM documents This writer was sitting at the nurse's station when a hospice CNA stated that someone had fell on the floor. Upon entering room resident was noted to be on right side with left hand on the floor in front of her. The second drawer to her nightstand was open. On the floor by her head was a yellow bead. Resident had proper fitting shoes on bilateral feet. Resident was assisted up to her bed. Resident has complaints of her left wrist hurting. Resident stated her bracelet had broken, she was trying to find a string, and that she slipped on the bead. This writer cleaned the floor of all objects and took all beads out of room. POA, DON (Director of Nursing), and (V17) notified. New orders received for x-ray to left wrist. No intervention noted for fall on 10/17/24. R47's Health Status Note dated 10/26/24 at 3:55 PM documents Resident inside therapy room and fell , complaints of pain to right hip. Called (V18) NP (Nurse Practitioner) to report fall. Pain level keeps increasing, NP states to send to ER (emergency room) for eval. 911 called for non-emergency transfer to (local hospital), (V19) POA called to report fall and orders from NP. No rotation or shortening noted, resident is able to put weight on Right hip but has pain with pressure. EMT (Emergency Medical Technician) arrived x 2 to transport, report called into (local hospital) ER, will update with results. R47's Health Status Note dated 10/29/24 at 11:33 PM documents Called (local hospital) and spoke with (hospital staff) RN, transferring resident to Metropolitan hospital) for fractured right hip. Resident did not have an intervention for the fall prior to this fall with an injury. Intervention for fall on 10/26/24 is for PT/OT (Physical Therapy/Occupational Therapy) to eval and treat, as needed. R47's Health Status Note dated 11/20/24 at 5:26 PM documents Resident fell at approx. 1645, unwitnessed. Surgical wound to R hip dehiscence. Resident found laying (sic) on her left hip in the doorway/hallway with pants to knees. Puddle of blood next to bed. Staff applied pressure to site. 911 called, paperwork gathered. Returned with ABD (Abdominal) pads. Ambulance arrived-- applied pressure dressing. Transferred to stretcher without complications. V17(Medical Director), DON and POA notified. R47's Health Status Note dated 11/20/24 at 10:40 PM documents (V18), NP for (R47), notified of resident's return and of sutures and of ABT (antibiotic) order. No intervention noted for fall on 11/20/24. R47's Health Status Note dated 11/30/24 at 8:35 PM documents called to resident's room. noted this resident sitting in doorway of room to hallway only wearing shirt. sitting on buttocks with knees bent. noted urine beside bed. alarm on bed on but not sounding. PROM (Passive Range of Motion) is wnl (within normal limits) for this resident. surgical site to right hip is intact. neuro checks started and are wnl. assist of 2 to get in chair. resident cleaned and put to bed per CNA. VS (vital signs) 97.8, 73, 18, 84/53. spO2 (oxygen saturation) 91% r/a. No intervention noted for fall on 11/30/24. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R47's Health Status note dated 1/10/25 at 4:25 PM documents resident had unwitnessed fall, resulting in a lump to the right side of the back of her head, range of motion completed, vitals WNL, resident responds appropriately per her baseline. MD (Medical Director) made aware, calls POA, no VM (voice mail) set up. poc (plan of care) ongoing. Intervention for fall of 1/10/25 is pressure pad alarm placed. R47's Health Status Note dated 2/18/25 at 11:15 PM documents called to resident's room for resident sitting on floor at FOB (foot of bed) on buttocks pulling on catheter. ROM and PROM without resistance or c/o pain/discomfort. neuro checks initiated and are wnl. assist of 2 to get back in bed. Noted large purple bruise to right hip area, resident able to move hip joint without c/o or resistance. MD notified. son(V19), notified. No intervention noted for fall on 2/18/25. R47's Health Status Note dated 2/24/25 at 7:40 PM documents called to oakwood hall for resident on floor. noted resident sitting on floor on buttocks in oakwood DR (dining room) with back against corner. resident unable to say what she was doing d/t (due to) usual confusion. c/o some pain to right leg with PROM but no resistance noted. assist to w/c (wheelchair) with 2 assists. neuro checks initiated and are wnl. VS 98.4, 91, 20, 94/57. spO2 96% r/a. Intervention for fall on 2/24/25 is anti-roll backs applied to w/c. R47's Health Status Note dated 3/12/25 at 8:00 PM documents Resident observed sitting on legs on floor in front of w/c. Barefoot (Removed socks per self). No c/o pain. Able to move extremities without difficulty. No noted injuries. Resident does not remember what was doing. VS: 124/71 97.7 69 20. SPO2 96% RA. Assisted to w/c. Alarm turned on and placed in w/c. Neuro-checks attempted. Resident refuses to participate. Closes eyes. Resident remains in area with staff. Intervention for fall on 3/12/25 is dycem (anti slip cushion) to w/c, gripper socks as tolerated. On 3/27/25 at 10:59 AM, V4, RN (Registered Nurse) stated that today is her second day working at this facility. She stated that she would add interventions to a resident's care plan after a resident has fallen. On 3/27/25 at 11:01 AM, V8, CNA stated that (R47) has a pressure alarm on her bed and wheelchair. She stated that R47 likes to stay busy, so they keep her busy to keep from falling. On 3/27/25 at 11:02 AM, V9, LPN (Licensed Practical Nurse) stated that today is her second day working at the facility. She stated that she thinks that it's the MDS person's job to add interventions to the care plans. On 3/27/25 at 11:03 AM, V5, LPN stated that it is the MDS, DON, and V3 the QA (Quality Assurance) nurse's job to add interventions to the care plans. On 3/27/25 at 2:19 PM, V21, MDS Coordinator/LPN stated that she just started as the MDS coordinator in December. She stated that it is her job to add interventions to the care plans after a resident falls. She stated that when she took over the MDS, it was a mess and care plans were not up to date. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 03/28/2025
NAME OF PROVIDER OR SUPPLIER Lakeside Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 University Avenue Carlinville, IL 62626	
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility's policy Accidents & Incidents dated 7/01/23 documents All accidents/incidents involving a resident will be documented in Risk Management. The nursing team will complete an investigation with the root cause and new interventions. Facility's policy Fall Prevention Program/Protocol dated 7/01/23 documents Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on interview, observation, and record review, the Facility failed to ensure enteral feeding was administered in a manner that prevents foodborne illness for 1 of 4 residents (R10) reviewed for nutrition in the sample of 31. Findings include: R10's Face Sheet documents R10 was admitted to the facility on [DATE] with diagnoses including brain stem stroke, functional quadriplegia, dysphagia (difficulty swallowing), and gastrostomy (feeding tube) status. R10's Minimum Data Set (MDS) dated [DATE] documented R10 was moderately cognitively impaired, dependent with mobility, and had a feeding tube. R10's Care Plan initiated 7/29/21 documents R10's nutrition must be provided via feeding tube due to history of stroke with dysphagia. R10's 3/13/25 Diet Order documents NPO (nothing by mouth). R10's Physician Orders dated 3/17/25 documents Jevity 1.2 per PEG (percutaneous endoscopic gastrostomy) via pump rate of 65 mL (milliliters) per hour with 150 mL water flush every 4 hours. On 3/25/25 at 9:15 AM, R10 was sleeping in bed in her room. Jevity 1.2 was infusing at 65 mL per hour via infusion pump. The Jevity 1.2 container was not dated or timed. On 3/25/25 at 9:17 AM, V5, Licensed Practical Nurse (LPN), stated if there is no date on the tube feeding bottle she will discard it for resident safety. She would also discard the formula if the date was more than 24 hours ago. On 3/25/25 at 2:20 PM, R10 was sleeping in bed in her room. Jevity 1.2 was infusing at 65 mL per hour via pump. There was no date or time on the tube feeding carton. On 3/26/25 at 8:38 AM, R10 was sleeping in bed in her room. Jevity 1.2 was infusing at 65 mL/hr via pump. The carton of tube feeding was labeled 3/25 and 13:17 (1:17 PM). On 3/26/25 at 3:15 PM, R10's tube feeding was infusing at 65 mL/hr via pump. The Jevity 1.2 carton still read 3/25 and 13:17. On 3/26/25 at 3:17 PM, V4 stated tube feedings can only hang for 24 hours after being spiked. V4 was notified that R10's tube feeding label was greater than 24 hours ago. On 3/26/25 at 3:40 PM, R10's Jevity 1.2 with the labels 3/25 and 13:17 was still infusing at 65 mL/hr via pump. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 10:18 AM, V2, Director of Nursing (DON), stated tube feedings should be dated and timed and discarded after 24 hours. The Facility's Undated Enteral Tube Feeding via Continuous Pump Procedure documents, On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed provide sufficient nursing staff to meet the needs of the residents residing in the facility when reviewed for Sufficient Staffing in the sample of 31. This failure has the potential to affect all 62 residents residing in the facility. Findings include: 1. On 3/25/25 at 12:20 PM, R4 stated they need more CNAs (Certified Nursing Assistants) everyday, all day. R4 stated the CNAs are leaving and not staying. R4 stated she is constantly having to wait for her call light to be answered and care provided. R4 stated she has had to sit in her urine for long periods of time and she is tired of it and is trying to move to another facility. R4's MDS (Minimum Data Set), dated 2/5/25, documents R4 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R4 is cognitively intact and is dependent with toileting. 2. On 3/25/25 at 9:35 AM, R2 stated there were only 2 CNAs on 3/22/25 during the night for the entire building. R2 stated it is harder to get care when there is less staff. R2 stated he takes a water pill and when he has to go, he has to go. R2 stated he will put his call light on, the staff will tell him they will be right back, but they don't, and he has an accident. R2's MDS, dated [DATE], documents R2 has a BIMS score of 15, indicating R2 is cognitively intact and dependent upon staff for toileting. 3. On 3/27/25 at 10:30 AM, during the resident council meeting, R18, stated they do not have enough CNAs to provide timely care. R18's MDS, dated [DATE], documents R18 has a BIMS score of 15, indicating R18 is cognitively intact and is dependent with toileting. 4. On 3/27/25 at 10:30 AM, during the resident council meeting, R21 stated they do not have enough CNAs to provide timely care. R21's MDS, dated [DATE], documents R21 has a BIMS score of 10, indicating R21 has moderate cognitive impairment and requires partial/moderate assist with toileting. 5. On 3/27/25 at 10:30 AM, during the resident council meeting, R31 stated they do not have enough CNAs to provide timely care. R31's MDS, dated [DATE], documents R31 has a BIMS score of 15, indicating R31 is cognitively intact and is dependent with toileting. 6. On 3/27/25 at 10:30 AM, during the resident council meeting, R37 stated they do not have enough CNAs to provide timely care. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R37's MDS, dated [DATE], documents R37 has a BIMS score of 15, indicating R37 is cognitively intact and is dependent with toileting. The Resident Council Minutes, dated July 2024 and January 2025, documents under concerns that there are not enough nurses. The CMS (Centers for Medicare & Medicaid Services, Payroll Based Journal Report, for fiscal year quarter one 2025 (October 1 - December 31), documents the facility has a one star staff rating. The Facility Assessment, undated, documents it is the facility practice to provide sufficient staff with the appropriate competencies and skill sets to provide care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnosis of the facility problem. On 3/26/25 at 8:05 AM, V5, Licensed Practical Nurse, stated she would like to see more CNAs during the day, their acuity is higher and when they are short, it makes for a long, hard day. On 3/27/25 at 12:49 PM V1, Administrator, stated they use a staffing calculator based off of the state's ratios when scheduling CNAs and Nurses. The CMS form 671, dated 3/25/25, documents there are 62 residents residing in the facility.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42636 Based on observation, interview, and record review, the facility failed to date two opened multi-dose vials of Tuberculin Serum when reviewed for medication storage and labeling. This failure has the potential to affect all 62 residents residing in the facility. Findings include: On 3/25/25 at 1:39 PM, the medication storage room refrigerator was observed with two multi-dose vials of Tuberculin Serum, opened and undated. The Tuberculin Product Information, dated October 2021, documents a vial of Tubersol (Tuberculin) which has been entered (opened) and in use for 30 days should be discarded. The Medication Storage Policy, dated 7/1/23, documents the facility stores all drugs and biologicals in a safe, secure, and orderly manner and in accordance with state and federal regulations. Medications shall be administered prior to the manufacture's expiration date. On 3/26/25 at 3:21 PM, V2, Director of Nurses, stated if the Tuberculin Serum is a multi-dose vial, it is used on multiple residents and should be dated when opened. The CMS (Centers for Medicare and Medicaid Services) for 671, dated 3/25/25, documents there are 62 residents residing in the facility.		