(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
IL6000723			B. WING		03/0	03/07/2025						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
LAKESIDE HEALTH & REHAB CENTER 1200 UNIVERSITY AVENUE CARLINVILLE, IL 62626												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	(X5) COMPLETE DATE						
S 000	Initial Comments			S 000								
	Complaint Investiga 2541894/IL187621-											
S9999	9 Final Observations			S9999								
	Statement of Licensure Violations:											
	300.615f)											
	Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information (f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.											
	This requirement was not met as evidence by:											
	Based on interview failed to check if a ron the Illinois Sex Constant of Corr for 1 of 4 residents Resident Criminal Fof 10.	newly admitted Offender Regis ections Sex R (R2) reviewed	resident was try or the Illinois egistrant page for request for									
	Findings include:											
	R2's Face Sheet, u admitted to the faci											
	There was no Illinoi check completed by identified in R2's re	y the facility for										

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/26/25

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

A. BOILDING:	STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1 AKESIDE HEALTH & REHAB CENTER 1200 UNIVERSITY AVENUE	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED								
1200 UNIVERSITY AVENUE			IL6000723	B. WING		C 03/07/2025								
1200 UNIVERSITY AVENUE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE													
CARLINVILLE, IL 62626	LAKESIDE HEALTH & REHAR CENTER 1200 UNIVERSITY AVENUE													
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLÉTE CROSS-REFERENCED TO THE APPROPRIATE DATE									
S9999 Continued From page 1 S9999	S9999	Continued From pa	ge 1	S9999										
On 3/6/25 at 12:30 PM, V1, Administrator, stated R2's registry checks would have been completed on the date on the sheet (9/13/24) and doesn't see where they were re-checked upon his new admission earlier this year. The facility's Identified Offender Guidelines, undated, documents to prevent abuse and promote the safety of residents, staff, and visitors from the risk of harm posed by residents with criminal backgrounds, Illinois long-term care facilities are required to conduct a background screening on all new admissions. (C)		R2's registry checks on the date on the see where they wer admission earlier the The facility's Identifundated, document promote the safety from the risk of hard criminal background facilities are require screening on all new	s would have been completed sheet (9/13/24) and doesn't re re-checked upon his new his year. ied Offender Guidelines, as to prevent abuse and of residents, staff, and visitors im posed by residents with ds, Illinois long-term care and to conduct a background											

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Illinois Department of Public Health STATE FORM