Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6002869 03/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ONE PERRYMAN STREET CEDAR RIDGE HEALTH & REHAB CTR** LEBANON, IL 62254 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation: 2342056/IL157434 S9999l Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)2)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health. safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of Attachment A notification. Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N IL6002869		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				(X3) DATE SURVEY COMPLETED	
		IL6002869	B. WING				C 03/17/2023	
NAME OF PROVIDER OR SUPPLIER STREET AND			DODESS OFF	DDRESS, CITY, STATE, ZIP CODE				11/2023
		ONE DE						
CEDAR	RIDGE HEALTH & RE	LEBANO	RRYMAN STI DN, IL 62254		33			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)			D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 1	S9999		į.		12	L1 45 8
	Section 300.1210 (General Requirements for				241	-	
2 YY	Nursing and Person	nal Care		17			- 3	35
100	b) The facility shall	provide the necessary care	=5.0			a e ⁸⁰ (3,80
19	and services to atta	ain or maintain the highest	11 10	g 20 ¹⁰				
	practicable physica	l, mental, and psychological		30 3				2) (0
	well-being of the re-	sident, in accordance with		W 255				
	each resident's con	nprehensive resident care	44	90				85
1	plan. Adequate and	properly supervised nursing	135	67			3.5	3 /
	resident to meet the	care shall be provided to each total nursing and personal		100		10		
	care needs of the re	3 total nursing and personal						
	cale Heeda OL 610 14	asident.		3 9				1,000
	d) Pursuant to sub	section (a), general nursing						=
	care shall include.	at a minimum, the following		V4				
	and shall be practic	ed on a 24-hour.	¥:	19				
1	seven-day-a-week i							113
	2) All treatmer	nts and procedures shall be		50 Vin				12
	administered as ord	dered by the physician.						
20.00	3) Objective of	bservations of changes in a	54	18 S				
	resident's condition	, including mental and	101	fi El				£
	emotional changes,	as a means for analyzing and	1	- 6				T #
. 3	determining care re	quired and the need for						
	made by nursing et	luation and treatment shall be aff and recorded in the	C) 40		24			- Se
	resident's medical re	and recorded in the		70	10	85		
	Todatica modica i	scora.		0				- E
21 25				a,				
	This REQUIREMEN	IT is not met as evidenced by:	.	:51		1	1	
.0			1	-			- 22	
9	Based on interview	and record review the facility						
-	failed to identify a ch	hange of condition for 1 of 8	36	10 A			1.2	SE 100
-	residents (R2), revie	ewed for change of condition			10			
	in the sample of 8.	The facility failed to	1				1	
2 8	adequately monitor	a resident (R2) taking diabetic	>					
	medication. The fac	vility failed to notify the						
- A	Salara da La La Caración de Ca	omity railed to flothly the						,
	physician of a blood	glucose level of 49. These						00
•	physician of a blood failures resulted in F	I glucose level of 49. These R2 being hospitalized with a cemia (low blood glucose	y.				1	0

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blood sugars checked before meals and at bedtime. Also, ordered to have Regular Insulin

PRINTED: 04/11/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6002869 03/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ONE PERRYMAN STREET CEDAR RIDGE HEALTH & REHAB CTR LEBANON, IL 62254 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) S9999 Continued From page 3 S9999 Humalog on the mentioned schedule with a sliding scale. 151-200 = 5 units, 201-250- 6 units, 251-300= 7 units; 301-350= 8 units." R2's Nurse's Notes dated 3/5/23 at 6:36 PM. given order by (V4) to have her glargine 15 units twice a day, (in the morning and at bedtime). R2's Medication Administration Records (MAR). dated March 2023 documents, R2's blood sugar glucose orders were not being documented until 3/5/23 and she missed, 4 blood glucose readings and no sliding scale insulin was administrated. R2's POS dated March 2023 does not document "Monitor blood sugar before meals and HS (bedtime), related to type 2 diabetes mellitus with diabetic chronic kidney disease" until 3/7/2023 (60 hours later). R2's Nurse's Notes dated 3/7/2023 at 5:21 PM. Resident had a blood sugar of 49 at 5:15 PM. Mild slurring of speech and sweating noted. No insulin given. Other due medication given with grape juice. Offered vanilla pudding, but resident refused. Resident stated that she will go to the dining hall to eat. For rechecking of sugar after she eats." R2's Nurse's Notes dated 3/7/2023 at 8:24 PM. "Found resident on bed with dinner slightly untouched at approximately 5:45 PM. She was staring blankly and with slurring of speech,

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incomprehensible. Immediately rechecked blood sugar 41 mg/dl. Offered milk and juice but unable

to swallow. Contacted DON, (Director of Nursing), for report. Glucagon 1mg/ml given intramuscularly for immediate treatment of hypoglycemia. Rechecked blood sugar after approximately 10 minutes. 45 mg/dl. Called

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"A"

prompt response."

on the urgency of the situation. For emergencies, they will call or page the physician and request a

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