| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002869 | A. BUILDING: _____ B. WING _____ | C 06/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR RIDGE HEALTH & REHAB CTR | ONE PERRYMAN STREET LEBANON, IL 62254 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Complaint Investigation: 2344949/IL160971 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.810a)<br>300.1210b)<br>300.1210d)1)3)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.810 General<br>a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002869 | A. BUILDING: _____ B. WING _____ | C 06/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR RIDGE HEALTH & REHAB CTR | ONE PERRYMAN STREET LEBANON, IL 62254 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 1<br>plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, the facility failed to have staff to monitor resident after returning from the hospital for one of three residents (R2), reviewed for monitoring in the sample of 17. This failure resulted in R2 being sent back out to the hospital after being found unresponsive with no heartbeat, spontaneous respirations, and blood pressure.<br><br>Findings Include:<br><br>R2's Nurse's Transfer Note dated 6/1/23 documents Sent To: a (local hospital) Date: 06/01/2023 14:45 (2:45 PM) the reason(s) for Transfer: Abnormal Pulse Oximetry (low oxygen | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002869 | A. BUILDING: _____ B. WING _____ | C 06/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR RIDGE HEALTH & REHAB CTR | ONE PERRYMAN STREET LEBANON, IL 62254 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

saturation), MD notified of transfer.

R2's Nurses Note dated 6/2/23 documents 3:53 AM resident (R2) came back to the facility. R2 was AO, (alert and oriented) x1-2; VS (Vital Signs), BP (blood pressure) 107/62, PR (pulse) 65, R (respirations) 22, O2 sat (Oxygen saturation), 83% on RA (room air). R2 was on 2L (liters), O2 via nasal cannula, but R2 keeps removing the nasal cannula, until such time that he refused it, and recent O2 81% on RA. HOB (head of bed) elevated, resident kept comfortable, bed on its lowest position.

R2's Nurses Note, dated 6/3/23 at 10:05 PM documents, sent this resident (R2) to the hospital. 02 saturation at 64% on room air. Resident (R2) refused to put on nasal cannula. Contacted MD (Medical Doctor), advised to send out to the hospital. Contacted resident POA (Power of Attorney), informed of resident being sent out to ER (Emergency Room).

R2's Nurses Note dated 6/4/23 at 4:30 AM documents, received R2 back from the ER. 02 saturation at 89% on room air.

R2's Electronic Health Record, Vitals Section dated 6/4/23 documents, O2 sats were only taken twice on 6/4/23 at 8:29 AM and 12:09 PM. On 6/4/23 at 12:09 PM oxygen saturation was 94%. On 6/4/23 at 8:29 AM oxygen saturation was 95%. R2's vital signs at 12:09 PM were temp (temperature) 97, pulse 70, and B/P, 110/56 and respirations were 18. R2's vital signs at 08:29 AM were temp 97, 72 pulse, B/P was 101/67, and 18 respirations.

R2's Nurses Note dated 6/4/23 at 9:31 PM documents at approximate 6:30 PM found this

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002869 | A. BUILDING: _____ B. WING _____ | C 06/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR RIDGE HEALTH & REHAB CTR | ONE PERRYMAN STREET LEBANON, IL 62254 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

resident (R2) unresponsive. HR 0, BP 0, not without spontaneous breathing, CPR initiated, called 911 and relatives were informed. Around 6:45 PM EMTs arrives, attached R2 to the cardiac monitor, with a rhythm, so he was transferred to a gurney, and left the facility around 6:50 PM with EMTs.

On 6/16/23 at 11:20 AM V4 (CNA) stated on 6/4/23 unknow time, he (R2) was found on the bed with no shirt, socks, and no shoes. He didn't have on any oxygen. His daughter came to nurses' station. She asked me to go to her father's room and check on him. I went into his room to help her get him situated, although I was assigned to C hall. He was laying horizontal on his bed. His roommate R4 was screaming for Norco, but the nurse for that hall didn't show up. So, I told the Corporate Staff in the facility. V6 (former Director of Nursing), sent V7 (RN) over to give R4 his medications. V8 was the CNA on that hall. The rest of the patients on that hall did not get their medications either. V7 (RN) was over there around 3pm or 4pm because R4 had been putting on his call light since 2:30 PM for Norco. On 6/1/23 I went into R2's room he didn't have on oxygen, and the oxygen level was 74, and he had to be sent out to the hospital.

On 6/20/23 at 11:15 AM V2 (Director of Nurses/DON) stated it depends on the resident and clinical condition. If the oxygen saturation is in the 80's, they should call the doctor, and if they are symptomatic, they should send them out right away.

On 6/16/2023 at 1:35 PM, V7 (RN) stated, "I am familiar with (R2), but I do not normally work with him. On 6/4/2023 I was working the C Hall, it was before 6:30 PM. Some of the nurse aids told me

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002869 | A. BUILDING: _____ B. WING _____ | C 06/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR RIDGE HEALTH & REHAB CTR | ONE PERRYMAN STREET LEBANON, IL 62254 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

they found (R2) unconscious. We started CPR (cardiopulmonary resuscitation) and called all for initial support. We did not know that no nurse was working the A hall until this happened. There was no nurse working the A hall when (R2) coded."

On 6/16/2023 at 10:02 AM, staffing schedules for 6/4/2023 was requested. There were two nurses on the A Hall and B hall that were crossed off and V14 was documented, as a call off. The only nurse not crossed off on the schedules was documented as V7 (Registered Nurse/RN). V13, V15, V7 were the nurses documented as working after the cross outs on the form.

On 6/16/23 at 1:30 PM V8 (Human Resources/CNA) stated, there were three nurses in the building, and they were to split A-hall. I don't know what rooms they were assigned. Around dinner time which is between 5:45 to 6 PM R2 ate a little because V9 (CNA) fed him. Around 6:30 PM I was collecting trays, I looked into R2's room and say he was unresponsive. I went into R2's room and rubbed his chest twice and then called his name out twice. I went out and I called V7 that was the first nurse I saw. V7 walked up to R2 and started CPR. It was noted that there were no meds passed on this A-hall and the nurses did not divide the hall and care for the 23 residents, there was CNAs that were caring for residents.

On 6/20/23 at 9:00 AM V11 (Medical Director) stated, he (R2) had just returned from the hospital, and he should have been checked on frequently. The vital signs are important, but checking on him was most important, and it could have contributed to him coding.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002869 | A. BUILDING: _____ B. WING _____ | C 06/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR RIDGE HEALTH & REHAB CTR | ONE PERRYMAN STREET LEBANON, IL 62254 |

| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 5<br>On 6/20/23 at 1:54 PM the facility, only provided a notification of change of condition policy. Not a change of condition policy. The Facility Policy entitled notification of change of condition dated 9/15/19 documents, it is the responsibility of the charge nurse to notify the family, DON (Director of Nursing), and Physician of any change in resident condition.<br><br>"A" | S9999 | | |