**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: A. BUILDING: \_ COMPLETED IL6002869 B. WING 06/09/2021 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) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **TAG** DATE DEFICIENCY S 000 **Initial Comments** S 000 Complaint Investigation #2143676/IL134341 #2143690/IL134353 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.610a) Resident Care Policies 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. 300.1210b) General Requirements for Nursing and Personal Care 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each Attachment A

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

resident to meet the total nursing and personal

care needs of the resident.

TITLE

Statement of Licensure Violations

(X6) DATE

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side using bed rail. Stand by assist/supervision to

R2's Fall Investigation Report, dated 5/25/21, documents, "I (V18) was called to the room by (V14, Certified Nursing Assistant, CNA). (V14) stated, She (R2) rolled out of bed, when she turned too far, for the CNA to place the (mechanical lift pad under (R2) her. V14 was attempting to get the resident up." The report

roll to her left side using bed rail.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
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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
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	documents R2 state she turned too far for mechanical lift pad	ed she rolled out of bed, when or the CNA to place a under her. The report ed she felt like her knees	ege			
	documents (R2) wa Room related to a fi She (R2) was diagn fractures. The root of rolled herself over in bed. (R2's) interven Brief Interview for M 15, and upon return	on Report, dated 5/25/21, also is sent to the Emergency all with pain to bilateral legs. osed with bilateral Femur cause of the fall was (R2) in the bed and slid out of the tion was resident (R2) has a lental Status (BIMS) score of to the facility (R2) will be assist with rolling in bed.				
	5/25/21, documents placing the (mechar (R2) turned and fell from hitting her hear when caught. (R2) thelp by turning by he (R2) rolled from the normal position." V1 5/25/21, documents resident (R2) was or rolling over in bed at the floor and staff st	on Witness Statements, dated (V14) stated "she was nical Lift Pad) under (R2) and to the floor. (V14) kept (R2) d, and supported her back old (V14) she was trying to erself and she turned too far, bed. The bed was in the 7's Witness Statement, dated in the ground. (R2) she was not rolled out. (R2) was left on ayed with her. The medical				
В	doctor was contacted the emergency room Medical Services (E the resident (R2) to Witness Statement, nurse was called to said the resident roll herself. (R2) confirm going to put a mechanical mechanical statement.	d and gave orders to send to a for evaluation. Emergency MS) arrived and transported a (local hospital)." V18's dated 5/25/21, documents the room by CNA (V14) that ed out of bed, while turning and this. CNA (V14) was anical lift pad under (R2), and was walking over to assist	•	#5 #### ####		

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Morbid Obesity, OSA (Osteoarthritis)."

R2's fall risk assessment, dated 05/30/21, documents R2 is at high risk for falls.

On 6/4/21 at 8:05 AM, R2 was lying in bed on an air mattress positioned on her back with bilateral

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Nurse (LPN), stated, "I was called to the room by the CNA (V14). The day shift CNA (V14) stayed over. When I got in the room, (R2) was lying on

On 6/3/21 at 2:51 PM, V18, Licensed Practical

pad (the mechanical lift pad) on the right side. I was walking around to the left side, and she (R2) threw her leg over and was falling to the floor. I ran around just in time to stop her from hitting her head. The agency CNA wasn't standing by the bed. I hadn't went to get the (the mechanical) lift yet. She (R2) moves better on her right side. She

the floor. She went to turn over, and fell from the bed. She felt her knees pop, when she landed.

(R2) doesn't move well on the left side."

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