STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	01/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

(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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)1) 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 300.1210 General Requirements for Nursing and Personal Care 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 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. c) Each direct care-giving staff shall review	S9999		

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and be knowledgeable about his or her residents' respective resident care plan.
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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide anti-anxiety medications as prescribed for 1 (R47) of 3 residents reviewed for behavior in the sample of 40. This failure resulted in R47 engaging in severe behaviors, including self-injurious behavior, and R47 was transferred to the local hospital for evaluation and treatment, requiring 6 staples to a head laceration.

Findings Include:

R47's Face sheet documented an admission date to the facility of 11/6/19. Diagnoses on this same form include, but are not limited to Major Depressive Disorder; Undifferentiated Schizophrenia; Schizoid Personality Disorder; Dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance; Anxiety Disorder; and Suicidal Ideations. V9 (Physician) is documented as being R47's physician.

Review of R47's Minimum Data Set (MDS), dated 1/3/24, documented a Brief Interview for Mental Status score of 9, indicating she has moderate cognitive impairment.

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Review of R47's Physician Orders document an open ended order with a start date of 12/11/23 for Lorazepam, 0.5 mg (milligrams), 1 tablet, by mouth twice a day.

R47's Plan of Care documented a problem area category of "Behavioral Symptoms" with problem start date of 07/09/21, and an "edited" date of 11/3/23 that stated, "Resident exhibiting problems as seen by: coming out of room and into common areas while being undressed, history of: rolling on floor, causing self inflicted wounds, throwing self against wall, furniture or the floor, physical aggression." An "Approach" listed for this problem area included an entry dated 07/09/21 that stated, "Provide meds as ordered and monitor effectiveness."

Review of R47's Medication Administration Record from 1/1/24 - 1/8/24 documented R47's did not receive any doses of her prescribed Lorazepam on 1/5/23, 1/6/23, 1/7/23, or morning dose on 1/8/23.

R47's Progress Notes on 1/7/24 at 12:47 pm, document the following entry, "at 1100 (11:00 AM) resident was found in hallway outside her bedroom door naked, rolling back and forth on floor. She was escorted back into her room, redressed. she immediately disrobed again and began running into doors et (and) walls. Took bed apart et pieces strewn about room. She began rolling over bed parts et onto the tile floor. Staff has intervened, resident assisted to standing pos. (position) et immediately throws self to floor again. 2 staff assist required due to resident running out of room, 3 doors down, witnessed throwing self onto floor, bed frame et onto mattress purposely banging head on wall behind her. Escorted back to her room, gown placed on

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her, CNA (Certified Nurse Assistant) w (with) resident for safety et this nurse to phone to call (V10, physician) (on call). While nurse is on phone CNA has requested assist et resident has thrown self onto floor, hitting head on electrical receptacle. small laceration just above rt (right) temple. Blood loss moderate. Order recvd (received) to send to ERD (Emergency Room Department) due to head injury. Code yellow initiated for additional staff support. Lying face down on tile floor when this nurse entered room. Log roll to assess w no impairment of extremities noted. Code yellow initiated for additional assist. Resident aware of surroundings et staff, limited verbal, pearl, pale, cool skin, resp (respirations) even et relaxed. ble ^ (bilateral lower extremities elevated) above level of heart. EMS (Emergency Medical Services) notified for transport, arrival, report et vs (vital signs) provided. Blanket lift by EMS team to cart, out of facility w EMS at 1125 (11:25 AM). stable w (with) c collar on per EMS."

The local hospital "After Visit Summary", dated 1/7/24, documents final diagnoses as: scalp laceration, initial encounter; head injury, initial encounter; ground-level fall. A computed tomography of her brain without contrast was completed with no acute intracranial hemorrhage noted. "Procedure Orders" documented in the same hospital documents provide note laceration repair was needed.

Review of R47's Progress Note documented an entry dated 1/8/24 at 2:23 pm, which stated "Report recvd (received) from (local hospital) for return to facility after tx. (treatment) scans were completed on neck, shoulders and back w no fx (fracture) identified. Mult (multiple) contusions, bruising et small skin injuries identified over posterior body surface. rt (right) temple lac

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(laceration) repair w (with) 6 staples placed. EMS has transported resident back to facility via cot, securement straps released after resident has agreed to lie still. Placed in recliner (due to bed remains disassembled at this time) via 2 man blanket lift, comfortable et stable. Staples are intact, large bandaide to left mid back area. Moving all extremities w no pain. Resident is quiet for approx (approximately) 1 hr (hour) et then becomes somewhat restless, fidgeting but manageable. Disrobing self repeatedly. Redressed et blanket provided for comfort, redirection is successful for brief time et activity is soon repeated. report to oncoming nurse at 1530 (3:30 PM) w (with) bed in process of being reassembled."

On 01/19/24 at 12:02 pm, V1 (Administrator) stated she acknowledges there was a delay in the facility receiving R47's Lorazepam medication, which resulted in R47 receiving missed doses of the medication. V1 stated they recently changed pharmacies, and despite their repeated faxing of the orders, the pharmacy was saying they were not receiving the order. V1 stated the medication could not be taken from the convenience kit due to being a controlled medication, with no physical prescription on file with the pharmacy.

On 01/19/24 at 12:42 pm, V1 stated she spoke with V8 (Nurse Practitioner/NP). V1 stated V8 expressed she believed she was notified of the medication not being available for R47. V1 stated V8 expressed the medication was left on hold until available due to R47 not experiencing any behaviors at that time.

On 1/19/24 at 10:01 am, V9 (Physician) stated his expectation would be for residents to receive medications as ordered. V9 stated R47 not

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S9999	Continued From page 5 receiving her anti anxiety medication could definitely play a role in the behavioral episode R47 experienced on 1/7/24, resulting in injury. V9 stated he is not sure why R47 wouldn't have received this medication, as he is available by phone 24 hours a day to give necessary orders. V9 stated he does not recall if he was notified, but can assume not, if it was not documented, and R47 continued to not receive her medication. The undated facility policy titled "Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion...The facility must make every effort to ensure that medications are available to meet the needs of each resident." (B)	S9999		