

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIDGEVIEW HEALTH &amp; REHAB CNTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 RIDGE LANE OBLONG, IL 62449</b>		
(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 Licensure and Certification Survey	S 000		
S9999	Final Observations  Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210d)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  a)Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest	S9999		

Illinois Department of Public Health

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

TITLE

(X6) DATE

Electronically Signed

11/02/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIDGEVIEW HEALTH &amp; REHAB CNTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 RIDGE LANE OBLONG, IL 62449</b>		
(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	<p>Continued From page 1</p> <p>practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>Findings include:</p> <p>Based on interview and record review, the facility failed to assess and manage pain for 1 (R198) of 2 residents reviewed for pain management in the sample of 34. This failure resulted in R198 experiencing severe pain and anxiety, resulting in a transfer to the ER (Emergency Room).</p> <p>Findings include:</p> <p>1. R198's Admission Record documented an Admission Date of 9/21/24 and listed diagnoses including Chronic Obstructive Pulmonary Disease and Anxiety Disorder. R198's Minimum Data Set dated 9/25/24 documented that R198 has no deficit in cognition. A Hospice Center Discharge Instructions Sheet dated 9/21/24 documented, "Medications: Ativan 2mg. (milligrams) per ml. (milliliter), give 0.5ml by mouth every hour prn (as needed) for anxiety. Morphine Sulfate 20mg./ml. give 0.5ml by mouth every hour prn for pain/SOB</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIDGEVIEW HEALTH &amp; REHAB CNTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 RIDGE LANE OBLONG, IL 62449</b>		
(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	<p>Continued From page 2</p> <p>(Shortness of Breath)." R198's September 2024 Physician's Orders documented an order, "Pain assessment every shift using 1-10 scale" with a start date of 9/21/24. There were no medications documented to be started on 9/21/24. A September 2024 Medication Administration Record (MAR) contained no documentation that Ativan or Morphine were administered in that month. The same MAR documented that R198's pain was not assessed until 9/23/24 on the 6pm to 6am shift, at which time it was "2" on a scale of zero to ten.</p> <p>R198's Nursing Progress Notes documented the following: 9/21/24, 11:00am: "Report received from hospice nurse. Nurse states that the resident is not eating any food but will occasionally sip on water or tea. She has a (name of indwelling urine catheter) in place. 2L NC (Oxygen at 2 liters, per nasal canula) for comfort. A&amp;O x2 (Alert and oriented to person and place) intermittent confusion. Taking morphine for pain and ativan for agitation round the clock. Nurse states that the resident is being discharged from hospice and all orders will need to come from the admitting physician." 9/21/2024, 1:33pm: "The resident arrived (to the facility) via EMS (Emergency Medical Services)." 9/24/24, 5:30pm: "Resident and family request to go to the ER for pain control." There was no documentation in the Progress Notes between 9/21/24 and 9/24/24 referencing R198's pain or anxiety.</p> <p>R198's Emergency Department (ED) Note dated 9/24/24 documented, "(R198) presented to the Emergency Department for evaluation of lower abdominal pain that has been going on intermittently for the last few days. The pain is dull, 8 out of ten." Under Assessment/Plan it</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIDGEVIEW HEALTH &amp; REHAB CNTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 RIDGE LANE OBLONG, IL 62449</b>		
(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	<p>Continued From page 3</p> <p>documents "Abdominal pain, acute; acute cystitis; hypokalemia; Diagnosis: Cystitis (Urinary Tract Infection); abdominal pain; generalized weakness." Under Medication Reconciliation it documents "Cephalexin 500mg.(miligram) oral every 12 hours for 10 days" and "Acetaminophen/Hydrocodone (Norco) 325mg-5mg, one tablet as needed every 6 hours for pain. Buspar 5mg. one tablet 3 times daily as needed for anxiety."</p> <p>On 10/08/24 at 12:01 PM, R198 was alert and oriented. R198 stated she was admitted on Saturday 9/21/24. R198 stated she was transferred from a hospice facility and was on round the clock medications for pain and anxiety. R198 stated she was told by facility staff that they would not be able to get these medications over the weekend. R198 stated shortly after her admission, she began to experience, "Terrible pain in my abdomen, and anxiety," which exacerbated her breathing problems. R198 stated finally on 9/24/24 her family asked that she be sent to the ER to get the pain and anxiety under control. R198 stated the ER physician put her on new medications for pain and anxiety.</p> <p>On 10/09/24 at 9:18 AM, V2, Director of Nurses, stated when R198 was admitted on Saturday 9/21/24, she was transferred from a hospice program. V2 stated R198 had been on round the clock Ativan and Morphine, but came without medications. V2 stated normally when they get a new resident on the weekend they make sure they have the residents medication by Friday, but in this case, they were told R198 would be there on Friday, but she did not show up. V2 stated she was called the next day to say that R198 had arrived without medication. V2 stated she called the Medical Director on 9/21/24 to get medication</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6007942</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/10/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIDGEVIEW HEALTH &amp; REHAB CNTR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>413 RIDGE LANE OBLONG, IL 62449</b>		
(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	<p>Continued From page 4</p> <p>orders for R198, but hard copy prescriptions were needed to get the medications and there was no way to obtain them. V2 further stated the pharmacy was closed, and even to take the medications out of the emergency kit, a written script was needed. V2 stated she is not sure why she did not document this call to the Medical Director. V2 stated on Monday 9/24/24, R198 was sent to the ED at the request of her family, where she was given orders for the Norco and Buspar. V2 stated every resident should have their pain assessed at least once every 12 hour shift.</p> <p>A Management of Pain Policy dated 5/16/22 documented, "Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement."</p> <p>A Medication Administration Policy dated 9/27/22 stated, "Medications will be administered safely to residents within the facility by licensed nurses at the specified time/timeframe, following the recommended administration method and will be documented as required."</p> <p>(B)</p>	S9999		