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 _____	01/30/2025

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

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4) 300.1210d)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 300.1210 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless	S9999		

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circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

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.

This REQUIREMENT is not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide effective pain management for 1 (R10) out of 1 resident reviewed for pain in the sample of 44. This failure resulted in R10 experiencing ongoing pain during peri-care as evidence by visual and audible reports of pain expressed.

Findings include:

R10 was readmitted to the facility on 1/12/25 from

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the hospital with diagnosis of, in part, surgical aftercare on the digestive system, calculus of bile duct with cholecystitis, biliary acute pancreatitis, acute and chronic respiratory failure, and transient cerebral ischemic attack.

R10's Minimum Data Set (MDS) dated 1/18/25, documented she is moderately cognitively impaired, is depended on staff for toileting hygiene, lower body dressing, rolling left and right, siting to standing and all types of transfers. R10's MDS further documented she required partial/moderate assistance from staff for personal hygiene and required substantial/maximal assistance from staff with showering/bathing.

R10's Care Plan dated 11/19/24 documented R10 has a self-care deficit as evidenced by needing assistance with activities of daily living (ADLs), including bathing requiring two-person physical assistance. R10's Care Plan further document she is at risk for pain and for staff to utilize the following interventions: in part, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, observe/document for probable cause of each pain episode, remove/limit causes where possible, observe/record/report to nurse resident complaints of pain or requests for pain treatment. R10's Care Plan continued to document she is incontinent of Bowel/Bladder and for nursing staff to report to MD abnormal symptoms or conditions; skin break-down, excoriation, rash, bladder pain, dysuria, urinary pain, retro-peritoneal pain, excessive or inadequate urinary output, or abnormal urine characteristics; color, odor, clarity, hematuria, Et cetera (etc.).

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On 1/27/25 at 4:01 PM, V21 (Licensed Practical Nurse/LPN) stated she was not aware of any reddened skin marks on R10's peri-region and was not told in report of any by the previous nurse. V21 stated a nurse will have to look at them but she had not seen them today yet. No pain score was documented for R10 on 1/27/25.

On 1/27/25 at 1:25 PM V19 (Certified Nursing Assistant/CNA) and V20 (CNA) entered R10's room to perform peri-care. R10's old brief was saturated with urine and stool upon removal. While performing peri-care, reddened areas with open wounds resembling skin tears/macerations were present on R10's right inner thigh, left butt cheek, and posterior left thigh as well as bright red skin to R10's labia. Any time one of those reddened areas was wiped R10 would cry "owe" while grimacing. V20 stated these marks have been there since she came back from the hospital and the nurses have been applying barrier cream to it, while the CNA's apply petroleum-based ointment. V20 stated V21 was aware of the red marks on R10. V20 applied petroleum-based ointment to all the reddened skin marks before completing care. No barrier cream was applied or in R10's active orders at this time. V19 and V20 completed peri-care at 2:10 PM on R10 on 1/27/25.

R10's Pain Scores did not have a score completed on 1/27/25. R10 had stated during peri-care on 1/27/25 while V19 and V20 were present, it was hurting her, and she yelled "owe" with each wipe while grimacing.

On 1/28/25 at 10:09 AM, V19 and V20 entered R10's room to provide peri-care after an incontinence episode. R10 stated my butt hurts, people don't care and don't do anything about it.

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R10 told V20 not to wipe so rough. R10 stated her pain was as 22 out of 10 on a pain scale. V19 and V20 proceeded to provide peri-care. V20 wiped R10's buttock and posterior thighs using up an entire package of wipes while R10 repeatedly yelled in pain with each wipe. V20 told V19 we will need another thing of wipes. V19 left to go get more wipes. V13 (CNA) returned with more wipes and V25 (Registered Nurse) with barrier cream. V20 completed peri-care on R10's front region using three wipes per section, each wipe having R10 yell out in pain. R10 stated it hurts, it hurts so much. V20 told R10 she was sorry but needed to get her cleaned up. V13 and V20 stated if a resident needs more time to finished completing a bowel movement, like R10 had been doing while V20 proceeded to wipe, they can offer a bedpan or put a brief on them and give them more time to finish. V19, V20, and V13 did not offer R10 more time to finish or a break from wiping nor any other pain-relieving alternative throughout peri-care.

On 1/28/25 at 10:04 AM, R10 stated she was not doing so good today after them wiping my butt so many times; it was very painful, I'm sore.

On 1/28/25 at 1:55 PM, R10 stated she is still in pain from being wiped, she is doing horrible. R10 stated the staff never offer her breaks if it is too painful for her while receiving peri-care. R10 stated she tells the aides she is in pain from them wiping her, but they tell her they need to get her cleaned. R10 stated they just started putting on that white barrier cream yesterday, before that it was the petroleum-based ointment the aides can apply but I've been complaining of pain down there for at least two weeks now.

On 1/29/25 at 10:28 AM, V1 (Administrator)

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stated she expects the Certified Nursing Assistants to report pain to other staff.

The facility's Activities of Daily Living (ADL) Support Policy dated 5/2/23 documented care and services to prevent and/or minimize functional decline will include appropriate pain management. The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate.

The facility's 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. The policy further documented they will achieve these goals through providing, in part, promptly and accurately assessing and diagnosing pain, encouraging residents to self-report pain, monitoring treatment efficacy and side effects, preventing and minimizing anticipated pain when possible, using non-pharmacological and complementary and alternative medicine when appropriate, and using pain medication judiciously to balance the resident's desired level of pain relief with the avoidance of unacceptable adverse consequences.

"B"