STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056671	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET , OLNEY, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Facility Reported Incident of 9/1/25/2610682	S0000		09/30/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 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 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	S9999		09/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056671	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	**900 EAST SCOTT STREET , OLNEY, Illinois, 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) COMPLETION DATE
S9999	Continued from page 1 participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide proper resident supervision during ambulation for 1 (R1) of 3 residents reviewed for accidents in the sample of 6. This failure resulted in R1 falling and sustaining a fracture to the right arm and elbow. Findings include: R1's Face Sheet documented an admission date of 8/25/2025 and diagnoses including unsteadiness on feet, metabolic encephalopathy, nondisplaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, wedge compression fracture of thoracic11-12 vertebra, subsequent encounter for fracture with routine healing, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R1's Minimum Data Set (MDS) dated 8/27/2025 documented in section C, that R1 had a BIMS (Brief Interview of Mental Status) of 7 indicating R1 had severe cognitive impairment. This same MDS documented under section GG-Mobility that R1 is dependent, which means helper does all of the effort. Resident does none of the effort to complete activity, or the assistance of 2 or more helpers is required for the resident to complete the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056671	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	**900 EAST SCOTT STREET , OLNEY, Illinois, 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) COMPLETION DATE
S9999	Continued from page 2 activity. R1's Care Plan documented a focus area of Falls with a start date of 8/26/25. Resident at risk for falling related to: history or falls, cognitive impairments, communication impairments, decreased safety awareness, difficulty using call light and/or requesting staff assistance, requires ADL (Activities of Daily Living) with transfers and mobility, incontinence, decreased strength and endurance and use of psychotropic drugs. R1's Fall Risk Assessment dated 8/26/2025 documented resident as a high risk for falls. R1's Physical Therapy Evaluation and Plan of Treatment dated 8/26/2025 documented under function mobility assessment of R1, walk 10 feet; dependent, distance; not applicable; assistive device; two-wheeled walker; assistance needed = max assistance x2, walk 50 feet with two turns; dependent, walk 150 feet; dependent, walking 10 feet on uneven surfaces; not applicable. The facility's "Incident Report" dated 9/1/2025 with the final investigation documented R1 had a witnessed fall in hallway staff was unable to reach resident to prevent fall. R1 sent to local emergency room at 4:02pm and sent back to the facility with a cast to right arm and orthopedic to follow. The local Emergency Room After Summary visit dated 9/1/2025 documented an imaging result of R1's right elbow with a comminuted fracture of the proximal humerus and mildly displaced fracture at the base of the olecranon process at the elbow. R1's Progress Note by V4 (Licensed Practical Nurse/LPN) dated 9/1/2025 at 4:11 AM documented at 1:50 AM, V5 (CNA) notified her that R1 had a fall in the hallway outside of his room. V4 documented that V5 stated, R1 stood up and fell before he could get to him with his walker. R1's Progress Note by V6 (LPN) dated 9/1/2025 at 4:06 PM, documents she had received a call from the imaging company that R1 did have a fracture present in elbow and shoulder. V6 documented ambulance was contacted at 1:50 PM and R1 left the facility via ambulance to local emergency room. On 9/11/2025 at 12:30 PM, V3 (Certified Nurse Assistant/CNA) stated, she did work the night R1 did have his fall on 9/1/2025. V3 stated, she had been up at the nurses' station around 1:50 AM on 9/1/2025,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056671	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	**900 EAST SCOTT STREET , OLNEY, Illinois, 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) COMPLETION DATE
S9999	Continued from page 3 after completing resident bed checks and documenting her rounds while V5 (CNA) had been with R1 in the hallway down by R1's room. V3 stated, R1 had stood up from his wheelchair and had been walking. V3 stated, V5 (CNA) did attempt to get R1's walker, but R1 stumbled and fell into the handrail. V3 stated, V5 did reach out to grab R1 after he hit the handrail, so he did not hit the floor. On 9/11/2025 at 12:47 PM, V4 (Licensed Practical Nurse/LPN), stated she had been the nurse working the night R1 had his fall on 9/1/2025. V4 stated, she had been taking care of another resident when V4 (CNA) came to get her to assess R1. V4 stated, R1 had been sitting in the hallway with his feet stretched out in front of him on the floor. V4 stated, she was notified by V5 (CNA) that R1 stood up from his wheelchair while holding the handrail and when V5 turned to go get R1's walker from his room, he noticed R1 stumbled and fell into the handrail. On 9/11/2025 at 1:30 PM, V6 (LPN) stated, she did have direct patient care with R1 the day he had his fall event on 9/1/2025. V6 stated, she was given report by V13 (LPN) that R1 had fallen on the night shift and had been complaining of right arm pain and swelling present. On 9/11/2025 at 2:16 PM, V5 (CNA) stated, he did work on the night R1 had his fall event on 9/11/2025. V5 stated, around 1:50 AM, he was trying to get R1 to sit back down in his wheelchair while walking in the hallway. V5 stated, R1 was standing and had a grip on the handrail. V5 stated, he then moved the wheelchair behind R1 and locked the wheels. V5 stated, he took 2 steps towards R1's room that is a couple of feet away, behind where R1 had been standing to get R1's walker. V5 stated, when he was a few feet away from R1, R1 stumbled and hit his right elbow on the handle rail. V5 stated, R1 is unsteady on his feet and requires assistance with mobility. On 9/11/2025 at 11:24 AM, V12 (Certified Occupational Therapy Assistant/COTA) stated, she actively works with R1 in therapy services. V12 stated, R1 had been admitted to the facility with a right hip and back fracture related to a fall. V12 stated, R1 is not safe to be left to self-ambulate and in her opinion R1 should not be left alone when attempting to stand or while standing. On 9/11/2025 at 2:45 PM, V6 (LPN) stated, R1 is unsteady on his feet and very impulsive. V6 stated, R1 should not be left unassisted while standing or	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056671	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	**900 EAST SCOTT STREET , OLNEY, Illinois, 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) COMPLETION DATE
S9999	Continued from page 4 walking. On 9/11/2025 at 2:54 PM, V1 (Administrator) stated, R1 is unsteady on his feet. V1 stated, it would be her expectation that V5 (CNA) remained with R1 and had another staff member bring him R1's walker. On 9/11/2025 at 3:10 PM, V2 (Director of Nursing/DON) stated, R1 is not steady on his feet and should not be left unassisted when standing or walking. On 9/11/2025 at 3:18 PM, V7 (Physician) stated, R1 is unsteady on his feet and should not be walking or standing without assistance. V7 stated, V5 (CNA) should have remained at R1's side and not left him unassisted. The facility's Fall Management Policy (revised 2018) documented under "Policy: it is the policy of (Name of Facility) to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measure which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary… Sample interventions for high-risk patients…use gait belts for all non-mechanical lifts and assists with transfers..." (B)	S9999		