| 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 11/04/2025 |
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| RICHLAND NURSING & REHAB | 900 EAST SCOTT STREET , OLNEY, Illinois, 62450 |

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| S0000 | Initial Comments<br><br>Facility Reported Incident of 10/27/25/2654603 | S0000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br><br>300.1035h)<br><br>300.1210b)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1035 Life-Sustaining Treatments<br><br>h) If no choice is made pursuant to subsection (c) of this Section, and in the absence of any physician's order to the contrary, then the facility's policy with respect to the provision of life-sustaining treatment shall control until and if such a decision is made by the resident, agent, or surrogate in accordance with the requirements of the Health Care Surrogate Act.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to initiate Cardiopulmonary Resuscitation (CPR) for 1 of 3 (R1) residents reviewed for death in the sample of 13. This failure resulted in facility staff not initiating CPR for R1 when R1 was found unresponsive on 10/27/25. R1 was found unresponsive by V7 (Certified Nurse Assistant/CNA) and V8 (CNA). V8 notified V4 (Registered Nurse) that R1 was unresponsive. V8 asked V4 if R1 was a Full Code or DNR (Do Not Resuscitate), and V4 responded she did not know. V4 stated she did not initiate CPR because there was nothing in her chart saying R1 was a Full Code or DNR. R1's progress note dated 10/15/25 documents R1 was a full code. R1 was pronounced dead at the facility by V4 and V6 (Licensed Practical Nurse).<br><br>This Past Noncompliance occurred between 10/27/25 and 10/28/25.<br><br>Findings Include:<br><br>R1’s Resident Face Sheet dated 10/29/2025 documents that R1 was admitted to the facility on 10/15/2025 with diagnoses that include cerebral infarction due to embolism, acute respiratory failure with hypoxia, acute on chronic diastolic heart failure, type 2 diabetes mellitus, anxiety disorder, chronic obstructive pulmonary disease, and unspecified intellectual disabilities.<br><br>R1’s Physician Order Summary with a date range of 09/29/2025 – 10/29/2025 does not document a code status.<br><br>R1’s care plan had no documentation of R1’s code status.<br><br>R1’s out of state hospital discharge summary with a print date of 10/15/2025 documented under section titled “Current Code Status” R1 is a full code.<br><br>R1’s Progress Notes document the following on 10/15/2025:<br><br>2:26 P.M., “report received from out of state hospital. 56-year-old female, full code, recent history of stroke on 10/02 and 10/06.” Signed by V13 (Licensed Practical Nurse/LPN – Agency). | S9999 | | |

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| S9999 | Continued from page 2<br><br>R1's History and Physical dated 10/16/2025 with a time of 2:04 P.M. authored by V11 (Nurse Practitioner) documented under code status "Unknown." The same history and physical goes on to document under "End-of-Life Treatment Status: none defined."<br><br>R1's Vital Report documents the following vital signs: 10/26/2025, 7:57 P.M. – temperature 97.6; 7:59 P.M. blood glucose of 115. On 10/26/2025 at 11:48 A.M. blood pressure 128/80.<br><br>R1's Progress Notes document the following on 10/27/2025:<br><br>6:09 A.M., "Upon assessment of resident, resident had no pulse, no respirations, no blood pressure at this time. 2nd nurse confirmed findings and time of death was called at 0550 (5:50AM). Called V11 (Nurse Practitioner) at approximately 552 (5:52 AM). Called R1's POA and informed of resident passing at approximately 555 (5:55 AM). Awaiting for the arrival of family to inform this nurse which funeral home she would need to be transported to." Signed by V4 (Registered Nurse).<br><br>On 10/29/2025 at 11:53 A.M. V7 (Certified Nurse Assistant/CNA) stated that rounds were completed on R1 at 3:00 A.M. on 10/27/2025 and R1 was alive. V7 stated around 5:30 A.M. she and V8 (CNA) went in R1's room to wake her and she was unresponsive. V7 stated V8 went to get V4. V7 stated V4 declared R1 deceased, and she started postmortem care. V7 stated that she is CPR certified but cannot find her card. V7 stated the only way she knows to verify if a resident is full code or a DNR is to get in the electronic medical record to see. V7 stated she was not aware of V7's code status. V7 stated she asked V4 if R1 was a full code or a DNR and V4 responded she did not know.<br><br>On 10/29/2025 at 11:59 A.M. V8 (CNA) stated V7 and herself were in R1's room at 3:00 A.M. on 10/27/2025 doing a bed check. V8 stated they had gone into R1's room around 5:30 A.M. to get her ready for the day. V8 stated that R1 didn't immediately respond so she went to uncover her to get her dressed. V8 stated when she uncovered R1 she realized that she was deceased and immediately went to get V4. V8 stated that V4 and V6 verified that R1 was deceased. V8 stated that during postmortem care on R1, she realized she wasn't sure if R1 was a full code or a DNR. V8 stated she left the room and went to the nurse's station to ask V4 if R1 was a full code or DNR. V8 stated V4 told her she did not know. V8 stated that she went back to R1's room and | S9999 | | |

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| S9999 | Continued from page 3<br>finished getting her ready for family to see. V8 stated she is not CPR certified and wasn't sure if she should initiate CPR or not. V8 stated the shift she was working was her third shift at the facility and she was not familiar with R1. V8 stated that R1 was still warm and herself and V7 had to remove a sweatshirt and sweatpants and put R1 in a gown. V8 stated R1 was not stiff at all and changing her clothes was not a problem. V8 stated that R1's room is always cold because she keeps the air on and a fan to help with her breathing.<br><br>On 10/29/2025 at 10:20 A.M. V4 (Registered Nurse/RN) stated that R1 was her normal self during her shift that started at 6:00 P.M. on 10/26/2025. V4 stated R1 took her medications and had no complaints of pain or anything. V4 stated that V7 (CNA) and V8 (CNA) had last completed bed check on R1 around 03:00 A.M. on the morning of 10/27/2025. V4 stated V7 and V8 went into R1's room to provide care and found her unresponsive. V4 stated R1 had no pulse or respirations. V4 stated she then went to the nurses station and called for V6 (Licensed Practical Nurse/LPN - Agency) to verify that R1 had passed. V4 stated that V6 agreed that R1 had no pulse or respirations. V4 stated she left the room and went to the nurse’s station to call the nurse practitioner and R1's family. V4 stated she was not familiar with R1 because she had not been at the facility very long. V4 stated she did not realize that R1 was a full code. V4 stated it is not an excuse, but there was nothing in R1's electronic medical record documenting whether R1 was a full code or a DNR. V4 stated since nothing was documented, she assumed that R1 was a DNR. V4 stated that R1 was unresponsive to touch and was warm to touch. V4 stated she now realizes that if you do not know a resident’s code status, you should treat them as a full code.<br><br>On 10/29/2025 at 11:19 A.M. V5 (LPN - Agency) stated she arrived for work on 10/27/2025 around 06:00 A.M. and sat down to get report from V4 (RN), V5 stated that V4 told her that R1 had passed away this morning and she had notified family and nurse practitioner. V5 stated that V4 told her that R1 was a DNR. V5 stated at that point she just started passing morning medications. V5 stated R1's family arrived around 6:30 A.M. and gave the name of the funeral home to the facility. V5 stated that around 08:00 A.M. she called the funeral home. V5 stated around 9:30 A.M. and 10:00 A.M. V2 (Director of Nursing) informed V5 that R1 was a full code and CPR wasn't started on R1. V5 stated V2 told her it was a reportable and to call the coroner. V5 stated that V2 came back to her awhile later and instructed her to call the police. V5 stated she then | S9999 | | |

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| S9999 | Continued from page 4<br>called the local police department. V5 stated later in the day around 1:30 P.M. V2 told her to call the doctor that V4 had notified, the Nurse Practitioner, and the physician because they all had to be notified per the facility policy. V5 stated that code status is on the banner in the resident's electronic medical record. V5 stated that if you look there it will tell you if the resident is a full code or a DNR. V5 stated R1's code status was not listed there, and CPR should have been initiated. V5 stated V4 said R1 was a DNR, and she did not think anything about checking to verify the code status. V5 stated she is CPR certified and received education the same day. V5 stated she was educated about what to do if a resident is a full code or a DNR and had to sign an in-service sheet.<br><br>On 10/29/2025 at 11:43 A.M. V6 (LPN - Agency) stated she was working the morning R1 passed away. V6 stated she was the nurse on the delta / garden's unit of the facility. V6 stated she was giving report to the oncoming nurse and heard a page. Upon answering the page, V4 was needing a second nurse to verify a death of a resident. V6 stated nothing seemed out of the ordinary. V6 stated when she got to the east / center unit, there was not a code going on. V6 stated V4 went to the room with her. V6 stated she checked for a carotid and radial pulse then used her stethoscope to verify there were no respirations. V6 stated she confirmed at 5:50 A.M. that R1 had passed. V6 stated that she had no idea that R1 was a full code. V6 stated that she assumed V4 knew the code status of her resident. V6 stated she does not usually work on east / center and was not familiar with the resident.<br><br>On 10/29/2025 at 12:11 P.M. V2 (Director of Nursing) stated she was made aware that R1 died before she arrived at work the morning of 10/27/2025. V2 stated she had received a message in the administration chat group that R1 had passed away. V2 stated she had her computer with her so she logged in to see if R1 was coded because she thought that R1 was a full code. V2 stated the nurse did not call her and notify her of the death. V2 stated she got to work around 9:00 A.M. on 10/27/2025 and she asked in morning meeting if they were going to discuss R1. V2 stated she looked at V9 (Social Services Director) and said there was nothing done for R1. V2 stated she was talking to her regional nurse and was having V5 help with notifications. V2 stated she had V5 call the coroner because it was not done yet. V2 stated she also had V5 notify the local police department because this was an unexpected death and reportable. V2 stated she had V5 notify R1's physician because V4 had only notified the nurse practitioner. V2 stated V9 is supposed to complete the | S9999 | | |

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| S9999 | Continued from page 5<br>POLST (Physician Order for Life Sustaining Treatment) for admissions. V2 stated she thought V9 had spoke with R1 about a code status but could not get it completed. V2 stated the facility policy is that if there is not a POLST in place the resident should be treated like a full code. V2 stated that R1 had been at the facility for 12 days and there was not a POLST completed in that time. V2 stated there are stars outside of the resident rooms by their name plates that have either a green star or a red star. V2 stated a green star means the resident is a full code and a red star means the resident is a DNR. All staff should know about the stars and the code status is listed on the banner in the electronic medical record. V2 stated that her expectation is for the nurse to perform CPR. V2 stated if a resident does not have a code status listed, the resident is to be treated as a full code. V2 stated that through her investigation and interviews, it was brought to her attention that V4 told a staff member that R1 was a DNR. V2 stated that she thinks all nurses and CNA's must be CPR certified. V2 stated that the facility is holding a CPR class on November 11th and 12th to get staff who are not certified can get their certification.<br><br>On 10/29/2025 at 12:38 P.M. V9 (Social Services Director) stated she prefers the residents come from the hospital with the POLST in place. V9 stated that R1 was difficult due to her having behaviors. V9 stated that during her assessment she noted R1 to score a 6 on the BIMS (Brief Interview for Mental Status). V9 stated she did not feel that R1 could sign it at that time and that automatically made her a Full Code. V9 stated she had not gone through all the paperwork from the hospital, but all residents should be classified as a Full Code until the POLST form is signed. V9 said it is common knowledge that if there is no POLST in the chart that the resident is a full code and CPR should be done. V9 stated the code status does go on the banner and any nurse can put the status there. V9 stated that R1 was her own POA (Power of Attorney) and did not feel with her BIMS score that she was appropriate to make those decisions. V9 stated that she had been busy helping in the business office and had not had time to go back and make sure the POLST was completed. V9 stated that once she heard that R1 had passed she was worried that no one had started CPR.<br><br>On 10/29/2025 at 1:00 P.M. V1 (Administrator) stated she came in around 8:00 A.M. on 10/27/2025. V1 stated that V5 told her that R1 had passed. V1 stated she asked V5 if R1 was a code or if the ambulance was called and V5 responded no. V1 stated that she was made aware that R1 did not receive CPR by V2 (Director of | S9999 | | |

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| S9999 | Continued from page 6<br>Nursing). V1 stated that CPR should have been initiated because there was not a POLST form in the medical record. V1 stated that it is not customary to wait a long period of time to complete the POSLT form. V1 stated she is not aware of what the policy says the time frame is on completing the POLST form, but she feels that it should be completed by day 4 or 5 after admission. V1 stated the last CPR training the facility provided was in August of 2025. V1 stated the facility is holding CPR classes on November 11 and 12th. V1 stated that there was an all-staff meeting scheduled for today 10/29/2025 but it was canceled and rescheduled for next week. V1 stated that staff will be educated on several policies. V2 stated that they have verified that all residents currently residing at the facility have a POSLT form in their chart.<br><br>On 10/30/2025 at 10:18 A.M. V11 (Nurse Practitioner) stated she saw R1 at the facility. V11 stated she attempted to talk to R1 about several things and R1 would not respond appropriately. V11 stated she did not have the opportunity to talk with R1's family regarding her wishes. V11 stated when she has a resident without a code status, she discusses it with V9. V11 stated that R1 did not have a code status and that automatically makes her a Full Code. V11 stated if there is no code status it is her expectation that CPR should be initiated. V11 stated she has been in healthcare for 40 years and that has not changed. V11 stated that V4 called her on the morning of 10/27/2025 and notified her of R1's death. V11 stated she was still asleep and did not ask any questions because she just thought it was a courtesy call. V11 stated that it is outside of her scope of practice to confirm a death and V4 should have called R1's medical doctor. V11 stated that she was not made aware by V4 that R1 did not receive CPR nor was she made aware of the time of death.<br><br>On 10/31/2025 at 11:18 A.M. V1 (Administrator) stated V4 was terminated 10/30/2025.<br><br>On 10/31/2025 at 10:31 A.M. V12 (Detective) stated he was notified by V18 (Sergeant) there was a death at the facility that needs investigated. V12 stated he spoke to V2 regarding the death of R1. V12 stated he was told by V2 that R1 was alive at 3:30 AM on 10/27/2025, and around 5:50 AM R1 was found deceased. V12 stated that the facility did not know if R1 was a full code or DNR. V12 stated that he has concerns on the facilities ability to follow policy. V12 stated that the coroner is not getting notified of deaths that occur at the facility. V12 stated when he spoke to V1, V1 was unaware that a nurse had called the police to report | S9999 | | |

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| S9999 | Continued from page 7<br>the death. V12 stated he was made aware that her chart was not completed at the time of death. V12 stated he felt that was odd because R1 had been at the facility for 12 days. V12 stated he felt the facility was negligent in the care of R1 and should have initiated CPR when R1 was found unresponsive.<br><br>Facility policy titled “CPR” with a revision date of June 2016 documented “Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician order and the resident’s advance directive.” Under section titled “Procedure: 1. CPR should only be performed on residents who are found unresponsive, and who are “Full code”. 2. If the resident is not breathing and does not have a pulse, then you should immediately have another nurse or staff member check the resident’s chart for their code status, and of the resident is a full code, announce a code on the public address system with the location of the resident and call 911. 3. If you find a resident who is unresponsive, and the resident is not breathing and has no pulse, but you have not yet determined the resident’s code status, then it is acceptable for you to begin CPR.”<br><br>The deficient practice was corrected on 10/28/2025 after the facility took the following action to correct the noncompliance:<br><br>V2 (Director of Nursing), V14 (LPN / MDS) and V20 (LPN) were educated by V10 (Regional Clinical Director) on 10/27/2025 on code status policy, death of a resident and change of condition policy, and the CPR policy.<br><br>V4 (Registered Nurse) was educated on 10/27/2025 by V2 on Code status policy, death of a resident, change in condition policy, notifications, and CPR policy.<br><br>V9 (Social Services Director) and V14 completed an audit on 10/27/2025 of all residents to ensure an order for a code status was in place, POLST form was in place and care plan indicates the order appropriately.<br><br>V3 completed an audit on 10/28/2025 of all staff who are CPR certified and schedule a class for the staff who are not.<br><br>On 10/28/2025 V3 reviewed the facility policy on CPR.<br><br>V2 initiated and completed the following in-servicing with all nursing staff on 10/27/2025 on CPR initiation policy including immediate initiation of CPR for all | S9999 | | |

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| S9999 | Continued from page 8<br>full code residents when unresponsive, documentation of a death, code status when to initiate CPR and change in condition policy.<br><br>V9 (Social Service Director) will be doing ongoing monthly audit to ensure all code status orders remain accurate and current for 3 months.<br><br>V2 (Director of Nursing) will monitor daily x 5 days, weekly x4 weeks, then monthly x3 months. Random audits of 3 resident records per week for accuracy of code status and 2 staff interviews to verify knowledge of protocol. Results will be reviewed by V1 (Administrator) and the Quality Assurance Committee monthly for 3 months.<br><br>Completion date 10/28/2025.<br><br>(A) | S9999 | | |