STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145135	A. BUILDING _____ B. WING _____	**03/17/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a Power of Attorney(POA) of a residents change in condition for one resident(R3) of 3 residents reviewed for POA notification in the sample of 25. Findings include: On [DATE] at 9:30 AM, V3 , family member of R3, stated she and V23 and V24, also family members of R3, were informed by staff that on February 2020, R3 had sustained a fall, and had also been treated for [REDACTED]. On 3/17/20 at 2:00 PM, V4 confirmed that he did not learn about the events until he was informed by V3. Nursing Progress Notes documented that R3 was treated for [REDACTED]. R3's Emergency Contact Information listed V4 as her POA. Review of R3's medical record produced no documentation that V4 had been notified of these events. On 3/17/20 at 2:20PM, V2, Director of Nursing, stated it would be nursing staff's responsibility to inform V4 of any changes in R3's condition. A Physician/Family Notification Change in Condition Policy. dated 11/13/18. stated, The facility will notify the residents legal representative .when there is A) An accident involving the resident .B) A significant change in the residents physical, mental, or psychological status.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on interview and record review, the facility failed to ensure residents grievances were addressed, regarding clothing items being lost or misplaced during laundering, for 4 (R7, R6, R9, R4) of 7 residents reviewed for lost clothing in the sample of 25. Findings include: Resident Council Meeting Minutes on the Harmony Building. dated 12/26/19. stated, Clothes not being labeled after being taken to be washed. Missing clothing. Clothes being returned to the wrong room/resident. On 3/12/20 at 10:00 AM, R7 was alert and oriented to time, place, and purpose. R7 stated, Stuff goes missing from the laundry. It's a constant problem. I have a denim dress that got put in the laundry about a month ago and I haven't seen it since. R7 stated staff looked for the dress, but none of the staff have ever offered to replace it. On 3/12/20 at 10:35 AM, R6 was alert and oriented to time, place, and purpose. R6 stated he has had a pair of suspenders missing which were sent to the laundry about a month ago. R6 stated staff looked for the suspenders, but none of the staff have ever offered to replace them. On 3/12/20 at 11:10 AM, R9 was alert and oriented to time, place, and purpose. R9 stated she is missing several pairs of pants which were sent to the laundry, and Some of them have been gone since I came here two years ago. R9 stated none of the staff have ever offered to replace the missing items. On 3/13/20 at 2:15 PM, R4 was alert and oriented to time, place, and purpose. R4 stated he has two pairs of jeans, a pair of sweatpants, one Tshirt, a pair of underwear and a pair of socks that have been missing for three weeks since being sent to the laundry. R4 stated none of the staff have ever offered to replace the missing items. During the interviews with R7, R6, R9, and R4, they all stated they had reported their concerns to staff, but couldn't remember the staff's names and no one ever followed through with their concerns regarding their lost clothing. On 3/13/20 at 3 PM, V17, Laundry/Housekeeping Supervisor, stated she was not aware of the missing items. V17 stated with a census of 120 residents, it is not possible for her to keep on track of every specific piece of clothing. V17 stated she is not sure if the facility offers to replace lost laundry. V17 stated if items are missing, it is most likely because nursing staff and/or residents do not let her staff know that items need to be labeled. V17 stated the labeler is located in the laundry. V17 stated she cannot think of a solution except possibly posting reminder notes in the nursing station. When asked if the issue could be discussed in Quality Assurance(QA) Meetings, V17 stated laundry issues are not discussed in QA. V17 further stated the only way she knows about missing items is through resident council notes, grievances, or being told by staff or residents, of which none of these occurred for these particular residents. On at 3/13/20 at 3:15 PM, V14, Social Services Designee, stated the facility does not have funds available for the replacement of lost laundry items. V14 stated she has access to about $50 per month for miscellaneous use. V14 stated this money is donated to the facility, not provided by its parent corporation. V14 stated she was not aware of the missing items as stated above, but she would follow up. A Grievance Policy, dated 03/08/17, stated, A resident has the right to voice grievances .grievances may be filed orally (meaning spoken), in writing, or anonymously .Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days, excluding (weekends and holidays).
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to respond in a timely manner to residents needs for toileting assistance and/or repositioning for 5 (R19, R18, R23, R24, R25) of 5 residents reviewed for assistance for dependent residents in the sample of 25. Findings include: On 3/12/20 at 10:00 AM, R7 was oriented to person, place, and time. R7 stated, Getting call lights answered is a big problem. My roommate (R19) needs help going to the bathroom, so I turn the call light on for her. It's not unusual for it to take an hour to get help. On 3/13/20 at 10:40 AM, R19 was observed sitting in her wheelchair in the doorway of her room, and the call light over the door was on. As V18, Certified Nursing Assistant (CNA), was walking by the door, R19 told V18 she needed to go to the bathroom. V18 stated she would be right back to help her. 18 minutes lapsed, and V18 again walked by R19, still sitting in the doorway. R19 again told V18 , loudly and with urgency in her voice, that she still needed to go to the bathroom. V18 again stated she would be back to help R19 . 14 minutes lapsed, and V16, Assistant Director of Nursing, walking by R19's room, was alerted by R19 of her need for assistance. V16 then went down the hall and got V20, CNA, to assist R19. R19's Minimum Data Set(MDS), dated [DATE], documented that R19 requires extensive assistance from at least 2 staff members for toileting. On 3/13/20 at 1:25 PM, R18 was sitting in his room in his recliner. The call light over his doorway was on. R18 was alert and oriented to person, place, time, and purpose. R18 stated, (Staff) do the best they can, but it takes too long to get any help around here. This (call) light has already been on a good 20 minutes. I want them to help me get out of this recliner, my legs are starting to hurt. I can't get up on my own. The call light remained unanswered an additional 21 minutes, until V14, Social Services Director, came in to R18's room with some documentation for R18 to sign, and then called for V18 to come help R18 . R18's MDS, dated [DATE], documented that R18 requires extensive assistance from at least two staff members for transfers. Resident Council Meeting Minutes for the East Building, dated 12/26/19, documented,Night shift not answering call lights. Staff staying by the desk as call lights are going off. Staff on the phone while in the hallways. Resident Council Meeting

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Minutes for the Harmony Building, dated 12/26/19, documented, Residents not being cared for in a timely way. Residents who need more constant care aren't receiving that level of care. Staff are always at the desk or on their phones. Resident Council Meeting Minutes for the East Building, dated 2/13/20, documented, Taking too long at night for call lights to be answered. A Concern/Complaint Form, dated 3/3/20, completed by V25, Certified Nurses Assistant, documented, (When V25 came on shift) (R23) L.C.(resident) had dried urine, brown rings on fitted sheet and crumbs all over the bed. The nurse was notified and saw the bed. (R24)C.W. (resident) had dried bowel(movement) in four different spots, and food crumbs all over the bed. Resident had old soiled clothes on as well. Nurse notified. No (incontinence) pads on either bed. Responsible department-night shift CNA. A Concern/Complaint Form, dated 3/5/20, completed by V25 documented, Resident (R25M.O. did not have call light all night long, I found it on the floor, and her water jug was empty and not beside her. She was very thirsty. A Call Light Policy, dated 11/28/12, stated, Resident call lights will be answered in a timely manner. All staff should assist in answering call lights. Nursing staff members shall go to (the) resident's room to respond to (the) call system and promptly cancel the call light when the room is entered. A Dignity Policy, dated 4/23/18, stated, The facility shall promote care for residents in a manner that maintains or enhances each residents dignity .(which should) include but is not limited to the following: Refraining from practices which is demeaning to the resident, such as .refusing to comply with a residents request for bathroom assistance .
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that prescribed medications were available for administration for 3 (R13, R15, R17) of 6 residents reviewed for medication administration in the sample of 25. Findings include: R13's March 2020 Physicians Orders documented an order for [REDACTED]. At 8:10 AM, V22 prepared R13's medications, and it was observed there were no [MED] 0.5mg.(milligrams) tablets in the medication cart for R13, and therefore it was not administered. At 8:30 AM, V22 prepared R15's medications and it was observed there were no [MEDICATION NAME] 2.5mg tablets nor [MEDICATION NAME] 5mg tablets for R15 in the cart, so they were not administered. At 9:00 AM, V22 prepared R17's medications and it was observed there were no [MEDICATION NAME] 75mg tablets nor a Tresiba [MEDICATION NAME] for R17 in the cart, so they were not administered. V22 stated resident's medications not being in the cart is a frequent problem. . Resident Council Meeting Minutes for the East Building, dated 12/26/19, stated, Pharmacy takes too long for medicine. . Resident Council Meeting Minutes for the Harmony Building, dated 1/9/20, stated, Medications coming later in the evening than they normally have been. A Medication Administration Policy, dated 1/1/15, stated, Medications must be administered in accordance with a physician's orders [REDACTED]., the right resident, the right medication, the right dosage, the right route, and the right time. On 3/17/20 at 2:20 PM, V2, Director of Nurses, stated the problem with medications not being in the cart may have to do with certain medications requiring a prior authorization from Medicaid. When this occurs, the pharmacy only dispenses an interim three day supply, which may not be enough if the preauthorization process takes longer than three days. V2 stated the pharmacy has recently contracted with a third party vendor to process these authorizations in a more timely manner.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to administer medications as ordered by the physician. There were 29 opportunities with 5 medication errors resulting in a 17% medication error rate. There were three (R13, R15, R17) of six residents reviewed for medication administration in the sample of 25. Findings include: R13's March 2020 Physicians Orders documented an order for [REDACTED]. At 8:10am, V22 prepared R13's medications and it was observed there were no [MED] 0.5mg.(milligrams) tablets in the medication cart for R13, and therefore it was not administered. At 8:30am, V22 prepared R15's medications and it was observed there were no [MEDICATION NAME] 2.5mg tablets nor [MEDICATION NAME] 5mg tablets for R15 in the cart, so they were not administered. At 9:00am, V22 prepared R17's medications and it was observed there were no [MEDICATION NAME] 75mg tablets nor a Tresiba Flextouch for R17 in the cart, so they were not administered. V22 made no effort to ask other staff where the medications might be located or how to access stock or emergency medications. V22 stated she is not employed by the facility but by a nurse staffing agency. V22 stated she believes the facility probably has stock and emergency medications available as most facilities do, but has been told that only a few staff are able to access these. V22 stated resident's medications not being in the cart is a frequent problem. On 3/13/20 at 1:00 PM, V22 stated the pharmacy had just brought the Tresiba and she administered it to R17. On 3/17/20 at 2:20 PM,V2, Director of Nurses, stated that when V22 could not find resident's medications in the cart, she should have located V2 or another nursing staff member for assistance in accessing stock and/or emergency supply medications. A Medication Administration Policy, dated 1/1/15, stated, Medications must be administered in accordance with a physician's orders [REDACTED]., the right resident, the right medication, the right dosage, the right route, and the right time