

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Richland Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744</p> <p>Based on interview and record review the facility failed to prevent physical abuse of a resident from another resident with a known history of aggression towards other residents in 1 of 3 residents (R1) reviewed for abuse in the sample of 33. This failure resulted in R1 being slapped, choked, and hit in the stomach by R2. These actions would cause a reasonable person to have feelings of fear and insecurity while living in their home.</p> <p>Findings included:</p> <p>R1's Resident Face Sheet documented R1 was admitted to this facility on 5/1/2023 with diagnoses of Dementia without behaviors, Psychotic Disturbance, Mood Disturbance and Anxiety. R1's MDS (Minimum Data Set), dated 5/13/2024, documented R1 with a BIMS (Brief Interview for Mental Status) score of 8 out of 15 total indicating R1 has severe cognitive impairment.</p> <p>R2's Resident Face Sheet documented R2 was admitted to this facility on 12/9/2023 with the diagnoses of Moderate Dementia with Agitation Intermittent Explosive Disorder, Delusional disorders and Cognitive Communication Deficit among others. R2's MDS, dated [DATE], documented R2 with a BIMS score of 0 out of 15 total indicating R2 has severe cognitive impairment. R2's Care Plan documented a focus problem of: Exhibiting problems of wandering, physical aggressiveness towards staff and other residents, sexually inappropriate towards other residents with a start date for this focus problem of 12/11/2023.</p> <p>On 8/3/2024 at 8:55am, V10 (Family of R1) said R2 has been a resident at this facility for about three months. V10 said R2 thinks R1 is his wife. V10 said R2 wants to sit by R1 in the dining room and at times puts his arm around R1. V10 said R2 will follow R1 around the unit and if R1 does not go with R2 then R2 becomes angry and becomes belligerent. V10 said R2 has attacked R1 twice, the first time R2 hit and choked R1 and the second time R2 punched R1 in the stomach. V10 said R1 was not injured, did not need to go to the hospital, quickly forgot what happened and calmed down after 90 minutes. V10 said she has told R1 to avoid R2 but R1 can't remember anything.</p> <p>On 8/5/24 at 9:30am R1 was noted in the dining room. At that time R1 was confused and unable to give any details of any altercations involving R2.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A facility form titled Grievance/Concern/Complaint form completed by V10 (Family) on 8/2/2024 documents the following, On two separate occasions (R2) has hit (R1). Previous interventions have failed. (R2) thinks (R1) is his wife and will not leave (R1) alone.</p> <p>A form in R2's EHR (electronic health record) titled Event Report and dated 6/9/2024 documented R2 had slapped and pushed (R1) up against a wall and started choking her.</p> <p>A Progress Note in R2's EHR documented, on 6/9/2024 at 1:47pm, V12 and V13 (both Certified Nursing Assistants/CNAs) witnessed (R2) slap (R1), pushed her against the wall and started choking her, CNAs were able to separate R2 and R1.</p> <p>A form titled Long Term Care Facility-Serious Injury, Incident and Communicable Disease Report dated 6/9/2024 at 1:00pm, documented a physical altercation between R2 towards R1 in which R2 became upset with R1, slapped R1 on the face, pushed R1 into the wall and placed his hands on her neck. Staff immediately intervened and separated R2 and R1. R1 was assessed and found to have no physical injuries.</p> <p>On 8/5/2024 at 9:45am, V9 (Licensed Practical Nurse/LPN) said on 7/31/2024 in the afternoon, R2 became confused and thought R1 was his wife. V9 said when R1 disagreed with R2 and said she was not his wife, R2 became physically aggressive towards R1. V9 said, I tried to get to R1 because I could see R2 getting angry with R1, but before I could get to them, R2 slapped R1 on the face, pushed R1 into the wall and put his hands on R1's neck. V9 said she, V12 and V13 immediately separated R1 and R2 and neither were found with any injuries after the event.</p> <p>A form in R2's EHR titled Event Report and dated 7/31/2024 documented R2 hit R1.</p> <p>A Progress Noted in R2's EHR documented the following on 7/31/2024 at 3:29pm, (R2) grabbed a hold of (R1's) walker and would not let go. (R1) yelled out and when staff came to help, R2 punched R1 in the stomach.</p> <p>A form titled Long Term Care Facility-Serious Injury, Incident and Communicable Disease Report dated 7/31/2024 at 3:30pm, documented a resident to resident altercation in which (R2) grabbed a hold of R1's walker and would not let go. (R1) yelled out for help and as staff approached, (R2) hit (R1) in the stomach. Staff separated R2 from R1. R1 was assessed and found to have no physical injuries.</p> <p>On 8/5/2024 at 10:00am, V11 (Housekeeper) said on 7/31/2024, she witnessed R2 become angry with R1 for not believing she was his wife and when R1 refused R2, R2 hit R1 in the stomach. V11 said she and V5 (CNA) immediately separated R1 and R2. V11 said neither R1 nor R2 had any injuries from the event.</p> <p>On 8/5/2024 at 10:45am, V1 (Administrator) said she investigated two allegations of abuse for R2 towards R1 for dates of 6/9/2024 and 7/31/2024 in which R2 was physically abusive to R1 and both events are substantiated as abuse. V1 said R2 did physically abuse R1 on both of those dates and new interventions have been put into place for both events. V1 said on 7/31/2024, R2 was placed on 15 minute checks and will remain on 15 minute checks indefinitely due to R2's cognitive level and repeated events with R1.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A facility policy titled Abuse Prevention Program (revision date 9/29/2022) documents the following: Definition of abuse in part as, The willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish and This facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment.		