

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  09/12/2025
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)
F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 included: 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 [DATE] 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 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 [DATE] 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, 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</p>		