STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145135	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to formulate or offer to formulate an Advanced Directive for 1 of 11 residents (R1) reviewed for Advance Directives in the sample of 13.The past non-compliance occurred on [DATE].Findings include:R1's Resident Face Sheet dated [DATE] documents that R1 was admitted to the facility on [DATE] 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.R1's Physician Order Summary with a date range of [DATE] - [DATE] does not include a code status or advance directive. R1's care plan does not include a focused area of care for R1's choice for Advanced Directives. On [DATE] at 9:24 A.M. V1 (Administrator) stated R1's POLST (Physician Order for Life-Sustaining Treatment) form had not been completed yet. V1 stated that she is not aware of what the policy says regarding when POLST forms should be completed and will have to pull the policy on it. V1 stated R1 was admitted on [DATE] from a hospital. V1 stated on the referral the code status was noted but the facility did not get a POLST form signed. On [DATE] at 10:18 A.M. V1 stated she is not sure who is responsible for POLST forms at this facility. V1 stated that she thinks the nurses are doing it on admission and if it doesn't get done then the social services director completes it. V1 stated that R1's POSLT was not completed on admission and social services had not got to it yet.On [DATE] at 12:11 P.M. V2 (Director of Nursing) stated V9 (Social Services Director) is supposed to complete the POLST for admissions. V2 stated she thought V9 had spoken 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. On [DATE] 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 stated that she had been busy helping in the business office and had not had time to go back and make sure R1's POLST was completed. On [DATE] at 10:18 A.M. V11 (Nurse Practitioner) 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.On [DATE] at 1:32 P.M. V3 (Regional Operations Director) stated that V9 will be looking at Code status for new admissions on the referral and the day after the resident is admitted . V3 stated the day the resident is admitted during morning meeting, the IDT (Interdisciplinary Team) team will discuss all new admissions and their code status. V3 stated V2 (Director of Nursing) will be completing all QA (Quality Assurance) audits and will provide feedback to the QA team at least monthly.On [DATE] at 1:38 P.M. V9 (Social Services Director) stated she is reviewing all new admits for Code status and accuracy of it. V9 stated she has been educated about code status and will monitor all new admissions. V9 stated that there has not been any new admissions since the audit was completed on [DATE]. V9 stated that she has been educated on the plan moving forward with all new admissions and to ensure an advance directive / code status is in place. V9 stated as part of the referral process, the code status / advance directive will be looked at to see if the resident is coming to the facility with one. V9 stated that if the resident does not have one, she will work to get it in place immediately. A facility policy titled Advance Directives with a date of February 2012 documented under section titled, Procedure: 1. Prior to or upon admission of a resident to our facility, the Social Service Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. 3. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident and/or his/her family members, about the existence of any written advance directives.Prior to the survey date, the facility implemented the following actions to correct the deficient practice. 1. A Quality Assurance and Performance Meeting was held on [DATE]. In attendance V1, V2, V3 (Regional Operations Director), V10 (Regional Clinical Director), V14 (Licensed Practical Nurse / MDS) and V19 (Licensed Practical Nurse) 2. Process/Steps to identify others having the potential to be impacted by the same deficient

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. 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 [DATE] documents R1 was a full code. R1 was pronounced dead at the facility by V4 and V6 (Licensed Practical Nurse). This failure resulted in an Immediate Jeopardy, which was identified to have begun on [DATE] when facility staff failed to initiate CPR after finding R1 with no pulse and no respirations. The failure resulted in R1 who was without a pulse and respirations not receiving life sustaining measures. R1 was pronounced deceased at the facility.V1 (Administrator), V2 (Director of Nursing) V3 (Regional Operations Director) and V10 (Regional Clinical Director) were notified of the Immediate Jeopardy on [DATE] at 3:36 P.M. This surveyor confirmed by interview and record review the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore Past Noncompliance.This Past Noncompliance occurred between [DATE] and [DATE].Findings Include:R1's Resident Face Sheet dated [DATE] documents that R1 was admitted to the facility on [DATE] 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. R1's Physician Order Summary with a date range of [DATE] - [DATE] does not document a code status.R1's care plan had no documentation of R1's code status.R1's out of state hospital discharge summary with a print date of [DATE] documented under section titled Current Code Status R1 is a full code.R1's Progress Notes document the following on [DATE]:2:26 P.M., report received from out of state hospital. [AGE] year-old female, full code, recent history of stroke on 10/02 and 10/06. Signed by V13 (Licensed Practical Nurse/LPN - Agency).R1's History and Physical dated [DATE] 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.R1's Vital Report documents the following vital signs: [DATE], 7:57 P.M. - temperature 97.6; 7:59 P.M. blood glucose of 115. On [DATE] at 11:48 A.M. blood pressure 128/80.R1's Progress Notes document the following on [DATE]: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).On [DATE] at 11:53 A.M. V7 (Certified Nurse Assistant/CNA) stated that rounds were completed on R1 at 3:00 A.M. on [DATE] 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. On [DATE] at 11:59 A.M. V8 (CNA) stated V7 and herself were in R1's room at 3:00 A.M. on [DATE] 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 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