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	05/12/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed implement PROM (Passive Range of Motion) exercises per COTA (Certified Occupational Therapy Assistant) recommendations for 1 of 3 (R1) residents reviewed for range of motion in the sample of 4.Findings include:R1's Face Sheet documented an admission Date of 3/17/26 and listed Diagnoses including Quadriplegia, Cervical Spine Fusion, and Neuromuscular dysfunction of the Bladder. R1's Minimum Data Set, dated [DATE] documented that R1 had no deficits in cognition. R1's Care Plan dated 3/30/26 did not document any problem areas related to R1 requiring restorative nursing or therapy services for quadriplegia.R1's Occupational Therapy Treatment Encounter Report dated 4/20/26 documented, Therapist educated staff on performing PROM (Passive Range of Motion) exercises daily to resident to prevent stiffness and contractures, as patient is unable to move his extremities on his own. Staff verbalized understanding. Therapist initiated self-care in-service this date to educate staff on daily bed baths on days he don't [sic] have showers to prevent odor and extra moisture. Staff verbalized understanding. Staff also educated to reposition patient every 2 hours for change in position to prevent skin breakdown. Therapist found a different type of tilt in space wheelchair for patient to trial since he states his back will hurt after sitting up for an hour in the other wheelchair. Therapist made adjustments to wheelchair to better fit the resident however patient did not want to get up this date as they think he may have a UTI (Urinary Tract Infection) and he isn't feeling well. Response to Session Interventions: Spoke with patients POA (Power of Attorney) this date regarding in-service that therapist educated staff on, and she asked therapist to place in-service reminders on patient's wall regarding daily baths, repositioning, ROM (Range of Motion) and wheelchair for staff to see every day to follow through. Therapist did place reminders on wall this date.On 5/6/26 at 1:40pm, R1 was alert and oriented to person, place, and time. R1 stated he is quadriplegic following a spinal cord injury in September 2025 and he hopes to be transferred to a facility that specializes in rehab for spinal cord injuries. R1 stated until that time, he is hoping not to regress in what abilities he still has. R1 stated he does not feel staff are doing an effective job in completing his ROM. R1 stated the only thing he is able to move is his head and neck. R1 stated he is afraid he will develop contractures.On 5/6/26 at 12:45pm, V9, Certified Occupational Therapy Assistant, stated R1's insurance has approved only 6 therapy visits since his admission and 4 have been used. V9 stated since her time with R1 is limited, she has educated CNA (Certified Nursing Assistant) staff that R1 should receive AROM (Active Range of Motion) to the head and neck and PROM (Passive Range of Motion) to the rest of the body at least once daily, and they could do this while giving R1 a bed bath. V9 stated she is not sure if the CNA's are doing it or not, and V9 stated recently the facility's two Restorative Aids were put back working on the floor and their positions will not be replaced.On 5/7/26 at 10:50am, V4, Certified Nursing Assistant, was observed performing PROM for R1. A sign on the wall by R1's bed read, ROM daily exercise: Please provide gentle PROM daily to patient's shoulders, elbows, wrists and fingers to prevent contractures as he is unable to move them on his own. Do not push above pain. When he says it hurts, only range his arm to that level. This ROM can be done during daily bathing/cleanup times. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Please provide slow controlled PROM exercise at least 10 reps (repetitions) each. The following planes did not receive 10 repetitions and received the number of repetitions as stated: Right shoulder-2 (repetitions). Right fingers and thumb-zero. Left wrist: 8. Left thumb and fingers: 4. Left elbow: 6. Left shoulder:5. Left ankle:7. Left knee: 5. Left hip abduction: zero. Right hip extension: 4. Bilateral toes: Zero. The resident did experience some leg spasms, but he had no complaints of pain and tolerated the procedure well. V4 stated R1 is to receive PROM once every 12-hour shift.On 5/8/26 at 940am, V9 stated she wrote up an in-service as stated above on 4/20/26 but apparently it was not shared with CNA staff, so she reprinted it today and it will be shared with staff. V9 stated the sign on R1's wall goes over ROM to the upper extremities, and that she should have also outlined the lower extremities, Which is common sense that those need PROM also. V9 stated she had only specified PROM was to be done once daily, but twice would be better. V9 stated she shared the in-service with V2, Director of Nurses, so that it could be added to R1's Care Plan. On 5/8/26 at 11:05am, V2 stated CNA staff will be in serviced on R1's restorative needs, and she will add them to the Care Plan.A Resident Mobility and Range of Motion Policy dated 10/20/25 documented, Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. 4. The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. 5. The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. 6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. 7. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. The resident and representative will be included in determining these goals and objectives.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide urinary catheter care according to professional standards of practice to prevent a Urinary Tract Infection for 1 of 3 residents (R1) reviewed for catheter care in a sample of 4.Findings include:R1's Face Sheet documented an admission Date of 3/17/26 and listed Diagnoses including Quadriplegia, Cervical Spine Fusion, and Neuromuscular dysfunction of the Bladder. R1's Minimum Data Set, dated [DATE] documented that R1 had no deficits in cognition. R1's Care Plan dated 3/30/26 documented a problem area, Resident requires EBP (Enhanced Barrier Precautions) related to (indwelling) catheter, with a corresponding goal, Resident will receive care from staff using EBP while maintaining a homelike environment and will remain free from infection through next review, with a corresponding intervention, EBP will be utilized while providing direct care (for example, wound dressing change, showers/bathing, transfers, hygiene, linen change, toileting assist, during therapy, (and) device care. R1's Care Plan also documents a problem area of Resident requires an indwelling urinary catheter r/t (related to) Neurogenic Bladder with a start date of 3/19/26 with interventions of Assess the drainage q (every) shift and prn (as needed). Record the amount, type, color, odor. Observe for leakage.R1's April 2026 Vitals Report document that R1's catheter was emptied once a day on the following dates: 4/6/26 at 10:47pm with an output of 1200cc; 4/7/26 at 2:28pm with an output of 2000cc; and 4/8/26 at 4:40pm with an output of 1400cc. There was no documentation of any urine output on 4/11/26, 4/18/26, and 4/25/26. R1's Urinalysis and Urine Culture dated 4/20/26 documented, Appearance: Cloudy. RBC (Red Blood Cells) 10-15, abnormal. WBC (White Blood Cells): Greater than 100, abnormal. Bacteria: Many, abnormal. Urine Culture: Greater than 100,000 gram negative bacilli recovered. R1's 4/22/26 Provider Note authored by V11, Nurse Practitioner, documented, Staff reports that resident has increased confusion. I am seeing him to follow up. History of present illness: Resident has a UTI. Continue to await final culture and sensitivity. Primary Care Physician started resident on Keflex which is to start this morning.On 5/6/26 at 9:50am, V7, Family Member of R1, stated on 4/7/26 at about 2pm when she came to visit R1, she noted his catheter bag was very full. V7 stated she turned on R1's call light to ask staff to empty it. V7 stated after 20 minutes, nobody responded so she emptied the bag herself, which contained 2000 cc (cubic centimeters) of urine. V7 stated there was an immediate return of 400cc of residual urine which had been backed up into the bladder.On 5/6/26 at 1:40pm, R1 was alert and oriented to person, place, and time. R1 stated he has had a UTI which he believes is due to the facility not providing proper catheter care and allowing his catheter bag to become too full, keeping the urine trapped in his bladder.On 5/7/26 at 10:40am, V4, Certified Nursing Assistant, was observed providing catheter care for R1. A sign on the outside of R1's door read, Enhanced Barrier Precautions. V4 entered the room without donning PPE (Personal Protective Equipment) and gathered supplies needed for the procedure, which she placed on a clean barrier on the overbed table. V4 washed her hands, donned gloves but no gown, asked R1 if he was ready to start, and approached the bed. The Surveyor, standing just inside the door asked V4 if R1 was on EBP, which V4 stated she didn't think so. V4 then began the procedure, again without donning a gown. Applying perineal cleanser to a wet washcloth, V4 cleansed the proximal end of the tubing and then went back and forth with the washcloth on the tubing, rather than going from the proximal to the distal end with one motion. V4 used the same technique to rinse and dry the tubing. Without performing hand hygiene and while wearing the contaminated gloves, V4 removed the clamp from the drainage tube and drained 500cc of urine into a urinal, and without sanitizing it, re-clamped the tube and placed it back in position.On 5/8/26 at 11:05am, V2, Director of Nurses, stated catheter bags should be emptied at least once every 12-hour shift and more often as needed. V2 stated no more than 1000cc of urine should be allowed to collect in the bag before it is emptied. V2 stated the urine output should be documented in (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's record. V2 stated residents with indwelling catheters are on EBP and staff should wear gown and gloves for contact with residents. V2 stated staff will be reeducated about EBP, catheter care, and documentation.An EBP Policy dated April 21st, 2024, documented, EBP will be used for any resident who meets the following criteria: Indwelling medical devices, such as, central lines, urinary catheters, feeding tubes, and tracheostomies. Residents who meet the above criteria, EBP are recommended when performing the following high-contact resident care activities: Indwelling medical devices care. Staff will wear gloves and a gown for High-Contact Resident Care Activities.An Emptying a Urinary Drainage Bag Policy dated July 2017 documented, Documentation: The following information should be recorded in the resident's medical record: The date and time the procedure was performed. The amount of urine emptied from the drainage bag. Purpose: The purposes of this procedure are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder, to measure output, and to obtain a sterile specimen. Empty the urinary drainage bag at least every eight (8) hours or more often if needed to keep the bag from becoming full. Do not allow the drain spout to come into contact with the measuring container, hands, or any other object. (Note: If accidental contamination occurs, wipe the drain spout with an alcohol sponge or swab.) Steps in the procedure: Place the clean equipment on the bedside stand or overbed table. Arrange the supplies so they can be easily reached. Wash and dry your hands thoroughly. Put on disposable gloves. Place a paper towel on the floor beneath the drainage bag. Position the measuring container under the drainage bag. Remove the drain tube from its holder. Open the drainage bag and let the urine flow into the measuring container. After the drainage bag has emptied, close the drain. Wipe the drain with an alcohol sponge or swab. Discard the sponge or swab into the designated container. Replace the drain tube back into its holder.A Urinary Catheter Care Policy dated July 2017 documented, Use standard precautions when handling or manipulating the drainage system. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. Do not clean the periurethral area with antiseptics to prevent catheter-associated UTIs while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate. Be sure the catheter tubing and drainage bag are kept off the floor. Empty the drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing, and prevent contact of the drainage spigot with the nonsterile container. Empty the collection bag at least every eight hours. For the male: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.