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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents were free from medication errors for 2 (R6, R63) of 13 residents reviewed for medication errors in the sample of 51.This failure resulted in R63, after receiving monthly doses of injectable atypical antipsychotic on 1/31/26 and 2/5/26, experiencing extrapyramidal symptoms and sedation. These symptoms resulted in R63 being sent to the local ER (Emergency Room) and poison control being contacted. Findings include: 1. R63's Face Sheet documented an admission Date of 3/24/20 and listed Diagnoses including Metabolic Encephalopathy, Schizoaffective Disorder, Bipolar Type, Hypertension, and Diabetes Type 1. R63's Minimum Data Set, dated [DATE] documented that R63 is severely cognitively impaired. R63's Care Plan dated 3/29/26 documented a problem area, Resident is at risk for adverse consequences related to receiving antipsychotic medication monthly for the treatment of Schizoaffective Disorder, with a corresponding goal, Resident will not exhibit signs of drug related side effects or adverse drug reactions. R63's Physicians Orders for January and February 2026 documented an order for Invega 234mg (milligram) IM (Intramuscular) with a start date of 9/10/23 scheduled once monthly on the 8th of every month. R63's January 2026 Medication Administration Record (MAR) documented that R63 did not receive the Invega injection on 1/8/26, documenting, Reason: Date changed. There was no documentation on the MAR to indicate R63 was given the Invega in January, and there was no documentation in the chart to indicate the Invega order date for the 8th of the month had been changed. R63's February 2026 Medication Administration Record documented that R63 received the Invega injection on 2/5/26, given by V27, Licensed Practical Nurse (LPN). A Long-Term Care Facility Serious Injury Incident Report dated 2/13/26 for R63 documented, 62 y/o (year old) male Schizoaffective disorder, DM (Diabetes Mellitus) Type 1, HTN (Hypertension) anxiety, hallucinations. BIMS (Brief Interview for Mental Status) =4 (severely cognitively impaired). 2/7/26: Resident noted to have increased lethargy, hand tremors, and increased need for assistance with transfers. Upon investion [sic] resident noted to have been administered monthly Invega injection on 1/31/26 and then again on 2/5/26. MD (Medical Doctor) and POA (Power of Attorney) immediately notified, and resident sent to ER (Emergency Room) for further evaluation. Testing included CBC (Complete Blood Count), CMP (Complete Metabolic Panel), Lipase, UA (Urinalysis), respritory [sic] panel, troponin level, EKG, blood gas, chest x-ray. No abnormalities noted on with [sic} testing except possible UTI (Urinary Tract Infection). Resident returned to the facility on 2/7/26 at 17:37 (5:37pm). (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 0760 Level of Harm - Actual harm Residents Affected - Few	Orders given to monitor VS (vital signs) for 2 weeks and continue to monitor for adverse drug reactions. 2/13/26: Resident continues to remain at baseline, UTI follow up completed and culture did not yield UTI. Investigation and audits initiated and interventions in place to prevent further med errors. Care plan updated, MD updated on results of investigation. Nursing Progress Notes documented the following: 1/25/26: Invega Sustenna injection not given; accidentally signed off by writer (V28, Agency Licensed Practical Nurse). Pharmacy does not have medication in stock and January injection was not received by facility and confirmed by pharmacy. Spoke to (pharmacy) and injection will be sent when available. 1/31/26: Resident Invega Sustenna injection given by writer (V28) this date in right deltoid; 1.5ml (milliliter) solution via 1.5-inch 22-gauge needle. Injection given on this date related to not being available on scheduled injection date of 1/24 (26). Patient tolerated well. 2/5/26: (R63) having increase in behavior symptoms and acting very resistant to any redirection for the past two weeks. Writer (V27, LPN) investigated when and if he received his last Invega injection, was not received on [DATE]th due to not being in stock. Writer located injection and gave it to (R63). Will update order in the Matrix to be received next month (March 2026) on the 5th. 2/7/25: Noted that resident received Invega injection on 1-31-(26) and again on 2-5-(26). Resident drowsy, experiencing some hand tremors, unsteady and not standing/bearing weight per his normal. Complains of nausea and back pain. Reporter [sic] to (V10, Psychiatric Advanced Practice Nurse) with N.O. (new order) to send to (local emergency room) for eval and tx (treatment) POA (power of Attorney) called and gave consent to send to ER (Emergency Room). 911 called to request an ambulance transfer. (Local ER) called and report given to ER nurse. Administrator called and notified of incident. Ambulance arrived at facility at 11:25 A.M. (and) transported resident to (local ER). Administrator instructed this nurse to notify resident primary MD (Medical Doctor) of incident. MD phone called and message left as he did not answer. No return call at this time. A Hospital Discharge summary dated [DATE] documented, Medication Problem: Chief Complaint: Patient is a resident of (the facility) and had received 230mg. Invega injection on the 31st (January 2026) then again on the 6th (February 2026), nursing home reports that they have noted tremors, and increased unsteadiness on his feet unable to give time line of onset of symptoms, patient normally has dysphagia, had reported back and abdominal pain to EMS (Emergency Medical Services). EKG (Electrocardiogram) shows a normal sinus rhythm with a heart rate of 94, no ST elevations or depression, normal EKGs. Spoke with the poison center and patient will be washed with the next 6 hours and patient then will be discharged to follow up with the primary care physician. CBC (Complete Blood Count) and chemistry are within normal limits, the troponin is negative, and lipase is negative, urine is positive for amorphous and bacteria. Patient is a waited [sic] in the emergency department for 6 hours. After speaking with the poison Center and patient is medically cleared to go back to the nursing home will continue to watch over the next 24 hours. The patient was discharged to home from the Emergency Department in stable condition. Clinical Impression: Medication overdose, accidental or unintentional, initial encounter. On 4/14/26 at 12:56 PM, R63 was observed in the facility dining room, in no apparent distress, up to the wheelchair and self-propelling. R63 was alert only to himself and answered questions incoherent responses. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 04/16/2026 at 3:18 PM, V10 stated the facility contacted her on 2/7/26 when they realized they had given R63 Invega Sustenna 235mg on 1/31/26 and again on 2/5/26, and it was ordered to be given monthly. V10 stated she did not know when it was given prior to 1/31/26. V10 stated staff had noticed R63 being more lethargic and having more tremors. V10 stated she ordered him sent to ER, he got back that same day, and they have been monitoring him for side effects. V10 stated she was not aware of R63 having had any long-term complications from the medication error. On 04/17/2026 at 11:29 AM, V2, Director of Nurses stated she was not yet employed at the facility when the medication error occurred and could not speak to what happened. On 4/14/26 at 12:11 PM, V1, Administrator, stated on 2/10/26, the facility did an Ad Hoc plan of correction for the medication error. On 4/21/26 at 1:16 PM, V27 (LPN) confirmed she administered the Invega on 2/5/26. V27 stated she was working with R63 on 2/5/26, and he was having increased negative behaviors. V27 stated she recalled looking at his record and at the MAR and the nurse's notes and it appeared the Invega had not been given as it was not available when it was due in January 2026, the date of which she could not recall. V27 stated she checked the medication room and the Invega was in there so she went ahead and administered it and changed the scheduling on the MAR to reflect it would now be due the 5th of every month. V27 stated it was later brought to her attention that R63 had received the Invega on 1/31/26. V27 stated she has never previously made any medication errors, but on 2/5/26 she was tired from working 12-hour shifts. At the conclusion of the survey on 4/21/26 at 3pm, V28 (Agency Licensed Practical Nurse) had not responded to the Surveyors phone messages requesting an interview. 2. R6's admission Record documented an admission date of 10/01/2025 and included diagnoses of metabolic encephalopathy, acute kidney failure, unspecified, unspecified dementia, unspecified severity, with other behavioral disturbance, type 2 diabetes mellitus without complications, anxiety disorder, unspecified, depression, unspecified, mood disorder due to known physiological condition with major depressive-like episode. R6's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 7, which indicates severe cognitive impairment. Under section N. High-Risk Drug classes: Use and Indication with documentation of resident taking an antidepressant. R6's Physician Orders documented Trazodone 50 milligrams (MG) tablet in the evening between 4:00 PM to 6:00 PM and Rosuvastatin 20 MG tablet in the evening between 4:00 PM to 6:00 PM. On 4/14/2026 at 12:40 PM, V12 (Licensed Practical Nurse/LPN) stated she had been working on 4/1/2026 when R6 had been given some of her evening medications in the morning and not in the evening as ordered. V12 stated, she had selected the wrong screen during the morning medication administration for R6. V12 stated, she had selected scheduled later medications and pulled all medications to be given. V12 stated, after giving R6 her medications she returned to sign them off in her EHR (electronic health record) when she noticed the times for R6's Trazadone 50 MG (Milligrams) by mouth once a day between 4:00 PM to 6:00 PM and Rosuvastatin 20 MG by mouth between 4:00 PM- 6:00 PM. V12 stated, she did notify V2 (Director of Nursing/DON) on the medication error. V12 stated, V2 (DON) notified family and V24 (Physician) and V24 requested R6 be sent to the local emergency room for further evaluation. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 4/14/2026 at 12:52 PM, V2 (DON) stated she had been notified by V12 (LPN) that she had given R6's Trazadone 50 MG (Milligrams) and Rosuvastatin 20 MG with her morning medications that had been scheduled for evening. V2 stated, she did contact V24 (Physician) and family. V2 stated, V24 notified her that he would feel better having R6 sent to the local emergency room for further evaluation. V2 stated, R6 had been sent via ambulance to the local emergency room. R6's Progress Note by V2 (DON) dated 4/1/2026 at 9:30 AM documented received call this am related to nurse stated she had given R6's evening medications (Geodon, Trazodone, Rosuvastatin) with morning medications. On assessment resident vital signs were within normal limits (WNL). Resident at normal level of consciousness (LOC). No signs or symptoms of distress. Contacted V24 (Physician) and received new order to send to emergency room. Contacted ambulance service. R6's Progress Note by V12 (LPN) dated 4/1/2026 at 12:40 AM documented resident returned from the local emergency by ambulance at 12:30 AM. R6's Medication Administration Record documented on 4/1/26 trazodone 50 MG tablet and Rosuvastatin 20 MG tablet under the time of 4:00 PM to 6:00 PM, were marked with V12's initials in parentheses for both medications, which indicates not given. R6's local emergency room After Summary visit dated 4/1/2026 documented under Chief Complaint: R6 had been brought into the emergency room department from the facility. R6 had been given her nighttime medications of trazodone and rosuvastatin in the morning instead. The facility's Medication Administration policy (undated) documented under Procedures.4) FIVE RIGHTS- Right resident right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after dose is prepared and the medication is put away.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide adequate CNA (Certified Nursing Assistants) staff to meet residents needs. This has the ability to affect all 76 residents living at the facility.Facility Grievance/Concern documents documented the following:On 10/15/26: No one answered call light from 2am or maybe 3am until 6am.On 12/23/26: Call lights not being answered timely.On 1/19/26: Had to wait 45 minutes with light on to get put on the toilet. Then had to wait 45 minutes to get off the toilet. On 04/14/2026 at 12:16 PM, R25 was alert and oriented. R25 stated when there is only one CNA (Certified Nursing Assistant) working, there have been times she has been left on the toilet over an hour. R25's Face Sheet documented an admission Date of 2/15/24.On 04/14/2026 at 2:20 PM, R14 was alert and oriented. R14 stated there is only one CNA working on the Delta Unit on the night shift, and he has waited over an hour on his call light. R14's Face Sheet documented an admission Date of 9/24/19.On 4/15/26 at 10:01am during the Resident Council Meeting, R5, who was alert and oriented, stated it can take up to an hour and a half to get call lights answered on night shift. R51, who was alert and oriented, stated it can take up to 45 minutes to get her call light answered. R5's Face Sheet documented an admission Date of 3/23/26. R51's Face Sheet documented an admission Date of 6/7/23.On 4/15/26 at 12:30 PM, R47 was alert and oriented. R47 stated that the night shift CNA's do not answer the call lights. R47 stated that the CNA's come in and turn off the light and tell her that they will be back because they have too much paperwork to catch up on, and R47 ends up waiting until morning shift comes in to help her. R47's Face Sheet documented an admission Date of 12/17/25.On 04/16/2026 at 12:27 PM, V11, Licensed Practical Nurse, stated she was working the night shift on the Delta Unit up until a few weeks ago and is now on days. V11 stated she has told administration they need another CNA on Delta on the night shift. On 04/17/2026 at 8:33 AM, V2, Director of Nurses, stated she is the staff member responsible for scheduling nurses and CNA's. V2 stated on the 6am to 6pm shift she schedules one nurse and 3 CNAs for the Center/East Unit, one nurse and 2 CNAs for the Delta Unit, and one nurse and 2 CNAs for the Gardens Unit. V2 stated on the 6pm to 6am shift, she schedules 1 nurse for Center/East and one nurse for Delta/Gardens, 2 CNAs for Center/East, 1 CNA for Delta and 2 CNAs for Gardens. On 04/17/2026 at 8:40 AM, V1, Administrator, stated the current census is 29 residents on Center/East, 30 on Delta, and 18 on Gardens. V1 stated the staffing pattern as described by V2 as above is meeting staffing requirements. Daily Assignment Sheets on the following dates documented that from 6pm to 6am, there was one CNA and one licensed nurse for the East/Center Unit, and One Nurse for the Delta and Gardens Units, two CNAs for the Gardens Unit, and one CNA for the Delta Unit: Saturday 3/14/26, Monday 3/16/26, Thursday 4/2/26, and Saturday 4/4/26.A Long-Term Care Facility Application for Medicare and Medicaid form dated 4/15/26 documented a total of 76 residents living at the facility.A Staffing Policy dated November 2021 stated, The facility provides adequate staffing to meet needed care and services for our resident population and according to regulatory staffing requirements (CMS (Centers for Medicare/Medicaid), IDPH (The Illinois Department of Public Health) (and) DHS (Department of Human Services). 3. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the residents comprehensive care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain infection prevention and control practices. This has the potential to affect all 76 residents living in the facility. The Findings Include: 1. R35's face sheet documents an admission date to the facility of 02/27/2026. The diagnoses listed include spinal stenosis, type 2 diabetes mellitus, generalized anxiety disorder, bipolar disorder, atherosclerotic heart disease if coronary artery, seizures, chronic diastolic heart failure, acute kidney failure, chronic obstructive pulmonary disease, and gastro -esophageal reflux disease. R35's care plan with a start date of 03/10/2026 documents a focus area of resident is frequently incontinent of bowel and bladder. Interventions listed include provide incontinent care as needed and toilet as scheduled and as needed. On 04/14/2026 at 12:10 P.M. R35 was observed sitting in the dining room with a puddle of liquid underneath his wheelchair. R35 rolled himself out of the dining room and into the hallway. R35 was observed rolling himself down center hall, all the way to his room on north hall. On 04/14/2026 at 12:13 P.M. observed V5 (Certified Nurse Assistant) cleaning the wet spot in the floor in the dining room. V5 cleaned the wet spots on the floor two foot outside the dining room and stopped cleaning the floor. On 04/14/2026 at 12:16 P.M. this surveyor observed wet spots on the floor down center hall. Wet spots were observed the entire length of the hallway and stopped at R35's room. On 04/14/2026 at 12:20 P.M. facility staff were observed walking down center hall and pushing wheelchairs out of the dining room stepping in the wet spots on the floor. On 04/14/2026 at 12:22 P.M. V4 (Certified Nurse Assistant) stated that R35 had an incontinent episode in the dining room and the puddle under his wheelchair was urine. On 04/14/2026 at 12:25 P.M., staff observed pushing residents out of the dining room and rolling wheelchair wheels through spots of urine on the floor. On 04/14/2026 at 12:27 P.M. V5 (Certified Nurse Assistant) stated she assumed that the puddle in the floor was urine from R35 being incontinent and she cleaned it up with bleach wipes. On 04/14/2026 at 12:30 P.M. V6 (Licensed Practical Nurse) stated she was unaware of the wet spots of urine in the floor but will have housekeeping clean it up. On 04/14/2026 at 12:32 P.M. the center hall floor was observed to have wet spots smeared down the entire length of the hallway. On 04/14/2026 at 12:35 P.M. staff were observed cleaning the floor. On 04/17/2026 at 12:10 P.M. V2 (Director of Nursing) stated she was not aware that R35 had an incontinent episode in the dining room. V2 stated she was not aware that there were urine wet spots (continued on next page)

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	145135	A. Building B. Wing	04/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the entire length of the hallway. V2 stated it should have been cleaned up immediately and no one should have walked through the urine spots on the floor. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated it is her expectation if a staff member starts to clean up urine on the floor, they should make sure that the entire area is clean and not just part of it. V1 stated the CNA should have cleaned up the entire hallway and then a housekeeping staff member should have gone behind her and mopped the areas. 2. R5's admission Record documented an admission date of 3/23/2026 and included diagnoses of sepsis, unspecified organism, altered mental status, disease of native coronary artery without angina pectoris, unspecified atrial fibrillation, and type 2 diabetes mellitus without complications. R5's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicates R5 is cognitively intact. Under section M-Skin Conditions documented R5's is at risk for developing pressure ulcers/injuries and had an unhealed pressure ulcer/injury area. R5's Care Plan had a focus area of admitted with skin ulcer/lesion and at risk for further skin impairment that included interventions of completing treatment as ordered. R5's Physician Orders dated 4/15/2026 documented to left heel: cleanse with wound cleanser, or normal saline, cover with calcium alginate with silver, and secure with dry, clean dressing daily and as needed. May use regular calcium alginate until calcium alginate with silver is available. On 04/16/2026 at 2:31 PM, Observed V3 (Assistant Director of Nursing/ADON) and V7 (Certified Nursing Assistant/CNA) completing R5's dressing change to his right heel. Observed V3 and V7 don personal protective equipment that included gowns and gloves prior to dressing change and placed protective barrier under left heel. During R5's dressing change, when V3 placed the calcium alginate with both hands to the right heel, she donned her left glove with no hand hygiene, placed on another glove to the left hand then used her right hand to hold R5's heel and her left hand to place the dressing over the calcium alginate. When attempting to place the dressing, the calcium alginate moved off of the blister. V3 then adjusted the calcium alginate with her right and left hand back to the center of the blister then reapplied the dressing with no doffing of gloves, hand hygiene or new gloves. On 4/16/2026 at 2:47 PM, V3 (ADON) stated, she should have completed hand hygiene when removing her left glove prior to donning a new glove. V3 stated, she should have donned both gloves, completed hand hygiene and donned new gloves prior to adjusting the calcium alginate and applying the dressing. On 04/17/2026 at 10:31 AM, V1 (Administrator) stated, her expectations are for staff to follow standard infection control practices during dressing changes. 3. On 04/17/2026 at 10:31AM V20 (Maintenance Director) stated the old dementia unit which consists of rooms 168 through 192 have been shut down for a long period of time. V20 stated he is not sure how long there have been no residents in that area of the facility. V20 stated he flushes the water lines on the unit that is closed every couple weeks. V20 stated that he does not keep a record of it but he just picks a day and completes it. V20 stated the water that is on the closed unit does not travel to any other part of the building. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated she is not sure how long there have been no (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents living in the area that is shut down. V1 stated she is not sure what the policy says as to how often the water lines should be flushed. V1 stated she would expect V20 to keep a log of it. A facility policy titled Legionella Water Management Program with a date of 07/01/19 documents under section titled measures to control introduction / spread of legionella: the chlorine and PH are monitored at least every 4 days to ensure chlorine levels are within the acceptable range and all areas that have the potential for contributing to bacterial growth are flushed every 4 days for 15 seconds at each point of stagnation. A Long-Term Care Facility Application for Medicare and Medicaid form dated 4/15/26 documented a total of 76 residents living at the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to establish an antibiotic stewardship program that includes protocols to ensure appropriate antibiotic use, and systems to monitor antibiotic outcomes. This failure has the potential to affect all 76 residents who reside at the facility.The Findings IncludeOn 04/16/2026 an infection control log was presented by V2 (Director of Nursing). The log contained a floor plan for the months of January 2026 - April 2026 that were color coated to differentiate between the different types of infections that residents were experiencing. The log contained a monthly summary of antibiotics that were utilized for the months of January 2026 - April 2026. That log had a print date of 04/16/2026 at 12:48 P.M. The log did not document resident symptoms, if any standardized criteria were used to justify and guide antibiotic use, when antibiotics were first initiated, if response to treatment was monitored, or any laboratory results when available to guide appropriate antibiotic use.On 04/17/2026 at 11:23 A.M. V7 (Regional Nurse) stated she has been monitoring the infections in the facility since January 2026. V7 stated she does not have any tracking, she logs into the computer and looks at cultures to see if there is a pattern.On 04/17/2026 at 12:10 P.M. V2 stated she started at the facility on 03/09/2026. V2 stated she is not sure what the previous director was tracking or how she was tracking infections. V2 stated the infection control binder she presented she found in the office when she started. V2 stated she is not sure that there was any tracking being completed on antibiotics, or what organisms were being monitored. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated she was not sure what the previous director of nursing was tracking. V1 stated V7 (Regional Nurse) is certified as an Infection Preventionist, and her understanding is that V7 was doing monitoring. Facility policy titled Antibiotic Stewardship - Review of Antibiotic Use and Outcomes dated October 2017 documents under policy statement antibiotic usage and outcome data will be collected and documented using a facility - approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility -wide antibiotic stewardship.A Long-Term Care Facility Application for Medicare and Medicaid form dated 4/15/26 documented a total of 76 residents living at the facility.

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observation, interview, and record review the facility failed to employ an Infection Preventionist who remains on site. This failure has the potential to affect all 76 residents who reside at the facility. The Findings IncludeOn 04/17/2026 at 11:23 A.M. V7 (Regional Nurse) stated she is responsible for the role of infection preventionist until V2 completes the course. V7 stated she is not sure how often she is actually at the facility. V7 stated she logs in remotely and reviews infections for the facility. On 04/17/2026 at 12:10 P.M. V2 (Director of Nursing) stated she has not completed the course, but she will be taking it to be the infection preventionist for the facility. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated V26 (Former Employee) was the infection preventionist for the facility. V1 stated that V26 quit without notice. V1 stated V7 (Regional Nurse) is who the facility is currently utilizing for the infection preventionist role. V1 stated that V7 is not in the building every day and looks at the facility data remotely. A Long-Term Care Facility Application for Medicare and Medicaid form dated 4/15/26 documented a total of 76 residents living at the facility.

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	145135	A. Building B. Wing	04/21/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to ensure quarterly assessments were completed within the required time frames for 7 (R2, R20, R48, R57, R68, R72, and R81) of 7 residents reviewed for quarterly MDS (Minimum Data Set) assessments in the sample of 51. The Findings Include:1. R2's face sheet documents R2 has an admission date to the facility of 11/22/2023. Diagnoses listed include retention of urine, unspecified dementia, major depressive disorder, unilateral primary osteoarthritis, anemia, obstructive sleep apnea, anxiety disorder, and hypothyroidism. On 04/15/2026 at 12:33 P.M. V7 (Regional Nurse) stated R2's quarterly MDS with an ARD (Assessment Reference Date) of 03/12/2026 has not been completed yet.2. R20's face sheet documents R20 has an admission date to the facility of 11/06/2019. Diagnoses listed include unspecified dementia, major depressive disorder, undifferentiated schizophrenia, anxiety disorder, neuroleptic induced parkinsonism, and unspecified intellectual disabilities. On 04/15/2026 at 12:33 P.M. V7 stated R20's quarterly MDS with an ARD of 03/12/2026 has not been completed yet. 3. R48's face sheet documents R48 has admission date to the facility of 12/09/2024. Diagnoses listed include unspecified dementia, pulmonary hypertension, hyperlipidemia, essential hypertension, obstructive sleep apnea, generalized anxiety disorder, and delusional disorder. On 04/15/2026 at 12:33 P.M. V7 stated R48's quarterly MDS with an ARD of 03/10/2026 has not been completed yet.4. R57's face sheet documents R57 has an admission date to the facility of 09/09/2025. The diagnoses listed include type 2 diabetes mellitus, hyperlipidemia, obstructive sleep apnea, chronic obstructive pulmonary disease, cognitive communication deficit and personal history of transient ischemic attack. On 04/15/2026 at 12:33 P.M. V7 stated R57's quarterly MDS with an ARD of 03/13/2026 has not been completed yet.5. R68's face sheet documents R68 has an admission date to the facility of 09/21/2023. The diagnoses listed include seizures, moderate intellectual disabilities, gastro esophageal reflux disease, and essential hypertension. On 04/15/2026 at 12:33 P.M. V7 stated R68's quarterly MDS with an ARD of 03/09/2026 has not been completed yet.6. R72's face sheet documents R72 has an admission date to the facility of 02/14/2022. Diagnoses listed include unspecified dementia, Alzheimer's disease, seizures, generalized anxiety disorder, chronic diastolic heart failure, and insomnia.On 04/15/2026 at 12:33 P.M. V7 stated R72's quarterly MDS with an ARD of 03/10/2026 has not been completed yet.7. R81's face sheet documents R81 has an admission date to the facility of 08/10/2024. Diagnoses listed include unspecified dementia, adjustment disorder, bradycardia, chronic kidney disease, depression, hypothyroidism, and essential hypertension.On 04/15/2026 at 12:33 P.M. V7 stated R81's quarterly MDS with an ARD of 03/11/2026 has not been completed yet. On 04/15/2026 at 12:33 P.M. V7 (Regional Nurse) stated that the facility does not have an MDS nurse. V7 stated that there is a regional nurse that is trying to complete all the MDS's. V7 stated the quarterly MDS's that have not been completed, corporate is working on them. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated V26 (former employee) quit without notice on 03/24/2026. V1 stated she was not aware that V26 was behind on completing MDS assessments. V1 stated the company does not have a policy on when MDS are to be completed they follow the RAI (Resident Assessment Instrument) Manual. V1 stated it is her expectation for the MDS to be completed on time.

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	145135	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review the facility failed to complete timely quarterly MDS (Minimum Data Set) for 4 (R8, R13, R51, and R56) of 4 residents reviewed for quarterly MDS assessments completed timely in the sample 51. The Findings Include:1. R8's face sheet documents an admission date to the facility of 10/01/2025. The diagnoses listed include metabolic encephalopathy, acute kidney failure, dementia, type 2 diabetes mellitus, anxiety disorder, essential hypertension, hyperlipidemia, gastro esophageal reflux disease, and mood disorder. A final validation report dated 04/14/2026, provided by V1 (Administrator) documents that R8's quarterly MDS (Minimum Data Set) was submitted on 4/14/26 and had a target/ due date of 03/03/2026. The same document had a warning message of assessment completed late: more than 14 days after the assessment reference date.2. R13's face sheet documents an admission date to the facility of 01/28/2020. The diagnoses listed include unspecified dementia, Type 2 diabetes mellitus, Alzheimer's disease, chronic kidney disease, essential hypertension, hypothyroidism, delusional disorder and B12 deficiency anemia.A final validation report dated 04/14/2026, provided by V1 documents that R13's quarterly MDS (Minimum Data Set) was submitted on 4/14/26 and had a target/ due date of 03/05/2026. The same document had a warning message of assessment completed late: more than 14 days after the assessment reference date.3. R51's face sheet documents an admission date to the facility of 06/07/2023. The diagnoses listed include spinal stenosis, low back pain, polyosteoarthritis, cardiomegaly, generalized anxiety disorder, and essential hypertension.A final validation report dated 04/14/2026, provided by V1 documents that R51's quarterly MDS (Minimum Data Set) was submitted on 4/14/26 had a target/ due date of 03/03/2026. The same document had a warning message of assessment completed late: more than 14 days after the assessment reference date.4. R56's face sheet documents an admission date to the facility of 07/17/2025. The diagnoses listed include unspecified dementia, generalized anxiety disorder, hypothyroidism, depression, and urinary tract infection.A final validation report dated 04/14/2026, provided by V1 documents that R56's quarterly MDS (Minimum Data Set) was submitted on 4/14/26 and had a target/ due date of 03/06/2026. The same document had a warning message of assessment completed late: more than 14 days after the assessment reference date.On 04/15/2026 at 12:33 P.M. V7 (Regional Nurse) stated that the facility does not have an MDS nurse. V7 stated that there is a regional nurse that is trying to complete all the MDS's. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated V26 (former employee) quit without notice on 03/24/2026. V1 stated she was not aware that V26 was behind on completing MDS assessments. V1 stated the company does not have a policy on when MDS are to be completed they follow the RAI (Resident Assessment Instrument) Manual. V1 stated it is her expectation for the MDS to be completed on time.

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation and interview the facility failed to ensure that residents were offered activities who chose to stay in their room for 4 of 4 residents (R22, R64, R66 and R80) reviewed for activities in a sample of 51.The Findings Include:1. R64's face sheet documents an admission date of 1/11/24 and includes the following diagnosis: chronic respiratory failure, major depression disorder, heart failure, anxiety, and morbid obesity.On 4/14/26 at 11:00 AM, R64 who is alert and oriented to person, place and time stated that she has not gotten any activities given to her since she can remember. R64 stated that due to her being bed bound she chooses to spend her time in her room rather than being transferred to a chair and out to the dining room for activities and meals. R64 stated that she used to receive puzzles and various items to color or read but honestly cannot remember the last time those were passed out to her. R64 stated that she would like to receive those again. 2. R66's face sheet documents an admission date of 2/6/19 and includes the following diagnosis: unspecified dementia, chronic obstructive pulmonary disorder, and alcohol abuse. On 4/15/26 at 1:30 PM, R66 who is alert to person and place stated that he does not get daily delights or puzzles passed out to him daily. R22 stated that he chooses to not to go to the activities but and he really likes to do word searches and puzzles so he would like to receive them to work on while he is in his room or sitting in the hall. 3. R22's face sheet documents an admission date of 6/16/25 and includes the following diagnosis: anxiety, congestive heart failure, diabetic neuropathy, obesity and anxiety disorder. On 4/15/26 at 2:00 PM, R22 who is alert to person, place and time stated that he does not get any type of daily handouts with activities on them. R22 stated that he doesn't know if he would enjoy them or not, but he would like to see what they are. 4. R80's face sheet documents an admission date of 12/21/23 and includes the following diagnosis: generalized anxiety disorder, chronic respiratory failure, hypertension, morbid obesity, and retention of urine. On 4/16/26 at 11:00 AM, R80 who is alert to person, place and time stated that he does not ever recall receiving daily handouts with reading materials and puzzles. R80 stated that he would like to see what they are and would possibly work on some of the puzzles. On 4/17/26 at 1:00 PM, V19 (Activities) stated that she passes out the daily delights along with the various puzzles and coloring pages in the dining room with the residents who attend the planned activities. V19 stated that she also passes them out the residents who choose to stay in their rooms, but there are days that she doesn't make it to all the rooms due to getting behind. On 4/17/26 at 9:30 AM, V1 (Administrator) stated that all residents should be receiving the activities packets whether they choose to attend the planned activities or not. V1 stated that she does not have an Activities policy, but this is her expectation.

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	145135	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide an environment free of hazards, implement appropriate interventions for falls, and provide a safe transfer with a mechanical lift for 4 (R2, R12, R22, and R81) of 4 residents reviewed for accidents in a sample of 51.Findings include: 1. R12's admission Record documented an admission date of 12/20/2023 and included diagnoses of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, hyperlipidemia, unspecified, essential hypertension, unspecified hearing loss, and unspecified ear. R12's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, which indicates severe cognitive impairment. Under section B. B1200. Corrective Lenses documented R6 used corrective lenses for her vision. R12's Care Plan had a focus area of risk for falls related to visual acuity impairments and cognitive impairments with interventions that included: Ensure resident is wearing eyeglasses as warranted. Ensure eyeglasses are clean and in good repair and ensure the floor is free of glare, liquids, foreign objects, with an approach start date of 1/5/2024. R12's Progress Note dated 1/5/2026 at 11:32 AM by V21(Licensed Practical Nurse/LPN) documented R6 was walking in dining room and therapy saw resident foot slip and res unable to correct balance and slide to floor without hitting head. Dining room floor appears to have some powder type substance making floor slippery. On 04/17/2026 at 12:07 PM, V1 (Administrator) stated her expectations would be for staff to clean up spills in a timely manner. On 04/17/2026 12:10 PM, V21 (Licensed Practical Nurse/LPN) stated she did work on 1/02/2025 when R12 had her fall in the dining room. V21 stated she did not witness the actual fall but V22 (Certified Occupational Therapy Assistant/COTA) did witness it. V21 stated V22 notified her that R12 had been walking in the dining room when she slipped in a powder substance. V21 stated, she had almost slipped herself in the substance. On 4/17/2026 at 12:18 PM, V22 (COTA) stated she had been working with another resident in the dining room on 1/5/2025 when R12 had been walking around the recliner and slipped in a powder-like substance in the floor. V22 stated she could see the powder on the floor by the chair but was not sure what it was. V22 stated she did notify V21 (LPN) of the event. 2. R81's admission Record documented an admission date of 8/10/2024 and included diagnoses of unspecified dementia, unspecified severity, with agitation, type 2 diabetes mellitus with other circulatory complications, F43.25 Adjustment disorder with mixed disturbance of emotions and conduct, bradycardia, unspecified, and repeated falls. R81's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, which indicates severe cognitive impairment. Under section GG-Mobility, R81 had documented chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or (continued on next page)

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	145135	A. Building B. Wing	04/21/2026

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Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair) as dependent meaning helper does ALL of the effort. Residents do none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the residents to complete the activity. R81's Care Plan had a focus area of risk for falls related to history of falls and cognitive impairments with interventions that included re-educate staff on proper use of fall prevention devices that are in place. On 04/14/2026 at 11:45 AM Observed R81 sitting at the dining room table being assisted with her lunch meal. R81's seat belt had been undone by V16 (Certified Nursing Assistant/CNA). While R81 had been assisted eating, V16 hollered out that R81 was going down and needed help. R81 had slid down to where her bottom was sitting on the wheelchair leg rest support with V16's right leg was holding R81 in place. V14 (CNA) came to assist V16 with moving R81 back into her chair and R81 finished eating by assist. On 4/15/2026 10:44 AM, V14 (CNA) stated, she and V16 (CNA) notified V15 (Licensed Practical Nurse/LPN) about R81 slipping from her wheelchair and sitting on the foot/leg rest areas with V16 applying her knee to stop R81 from going to the floor. V14 stated, she does not know what time it was that she reported to V15, but she did. On 4/15/2026 at 10:05 AM, V15 (Licensed Practical Nurse/LPN) stated V14 and V16 did report to her around 5:30 PM - 6:00 PM that R81 did slide down in her wheelchair but did not hit the floor. V15 stated, since R81 did not slide into the floor, she did not report the occurrence to V2 (Director of Nursing/DON) or implement an intervention. On 4/15/2026 at 10:25 AM, V16 (CNA) stated she had been assisting R81 with her lunch meal and had unbuckled her seatbelt during the meal. V16 stated, while feeding R81 she had been scooting down in her wheelchair and before she knew it, R81 was sitting on the footrest of her wheelchair. V16 stated, she placed her right knee against R81's knees to keep her from sliding into the floor. V16 stated, she requested assist from V14 (CNA) to help pull R81 up in her wheelchair to finish eating. V16 stated, she did report this occurrence to V15 (LPN) shortly after, but she did not get a paper to sign about a new intervention put in place from V15 (LPN). V16 stated, the facility policy to notify the nurse on the floor of the occurrence, then the nurse on the floor would notify V2 (DON) and place a new intervention in place. The facility's Falls Management (revised April 21,2022) documented under Policy: It is the policy of facility name to assess and manage resident falls through prevention investigation, and implementation and evaluation of interventions. Under Definition: The definition of a fall refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. 3. R22's face sheet documents an admission date to the facility of 06/16/2025. The diagnoses listed include type 2 diabetes mellitus, unspecified atrial fibrillation, anxiety disorder, depression, insomnia, unspecified systolic heart failure, hyperlipidemia, gastro esophageal reflux disease, benign prostatic hyperplasia, morbid obesity, contracture of right knee, contracture of left knee, and chronic pain. R22's physician order report with a date range of 03/16/2026 – 04/16/2026 documents an (continued on next page)

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	145135	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for R22 to be transferred with a mechanical lift. R22's care plan with a start date of 06/26/2025, has a focus area of R22 needs set up/supervision to substantial assistance for most activities of daily living. Mechanical lift for transfers. Interventions listed include stand-up lift for transfers with two assist. R22's MDS (Minimum Data Set) dated 12/19/2025 documented in section GG Functional abilities that R22 is dependent for sit to stand and chair to bed / bed to chair transfers. On 04/16/2026 at 11:01 AM, V8 (Certified Nurse Assistant) was observed going into R22's room alone. V8 left the door open while she pushed the mechanical lift into the room. V8 then hooked R22's mechanical lift sling to the mechanical lift. V8 then walked out of the room, grabbed gloves walked back into R22's room and closed the door. Several minutes later V8 walked out of R22's room by herself pushing the mechanical lift. There were no other staff members observed leaving the room. On 04/16/2026 at 11:49 P.M. V8 (Certified Nurse Assistant) stated that she completed the mechanical lift transfer by herself on R22. V8 stated she knew that she needed to use two people for the transfer with the mechanical lift. V8 stated she does not have a reason for not going to get another staff member before proceeding with the mechanical lift transfer. On 04/17/2026 at 12:10 P.M. V2 (Director of Nursing) stated she was not aware any staff were using the mechanical lift by themselves. V2 stated there should always be two staff members present when a resident is transferred with a mechanical lift. V2 stated she plans on educating staff today about mechanical lifts. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated the mechanical lift should only be used when there are two staff members present. V1 stated no staff should be using the mechanical lift by themselves. A facility policy titled Mechanical Lift with a date of 09/08/2023 documented under section titled policy: The mechanical lift may be used and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel. Two staff members are required when transferring a resident with a mechanical lift. 4. R2's face sheet documents an admission date of 11/22/2023. This same document includes the following diagnosis: unspecified dementia, major depressive disorder, anxiety, and visual hallucinations. R2's Progress notes dated 12/5/25 at 8:18am documents, Resident was yelling out for help. Found laying on her room floor with her head towards her window and feet towards the door on her rt (right) hip. No deformity noted, states severe pain deep in the joint area. Order received to send to the ER (Emergency Room) for further evaluation d/t (due to) increased pain and discomfort. Redness noted over the hip joint R2's Event Report completed 12/5/25 has multiple sections of the investigation left blank including areas such as History of falls, what was the date of the fall, any recent change of condition, environmental issues identified, etc. This area is used in determining the root cause of the unwitnessed fall and proper interventions to prevent future falls. (continued on next page)

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/26 at 11:00 AM, V1 (Administrator) confirmed that this part of the investigation to the root cause of the fall was not completed. V1 stated that she was not working in the facility at the time of the fall and the nurse is no longer an employee at the facility. V1 stated that this portion of the event should be filled out to ensure a thorough investigation into the fall is completed.

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	145135	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review the facility failed to offer residents food alternatives per personal preferences for 4 of 4 residents (R22, R64, R66, and R80) reviewed for meal alternatives in a sample of 51. The Findings Include:1. R80's face sheet documents an admission date of 2/20/2023. R80's April Physician's Order sheet documents R80 has a regular diet ordered.On 4/14/26 at 12:00 PM, R80 was observed in his room with his lunch tray on his bedside table. R80 who was alert to person, place and time, stated that he will not eat the carrots because they serve them too often. R80 stated that he ate the baked pasta but threw out the rock-hard garlic bread that was in his trash can next to his recliner. R80 stated he never gets to make food choices prior to his meal; he just finds out what is being served when it is delivered. R80 stated that he chooses to stay in his room all day including mealtime and does not participate in the activities by choice. 2. R64's face sheet documents an admission date of 1/11/24. R64's April Physician's Order sheet documents R64 has a regular diet ordered.On 4/15/26 at 11:00 AM, R64 who was alert to person, place and time, stated that she never gets asked what she wants to eat prior to the meal. R64 stated that she gets what is served to her but would like to know what the other choices are. R64 stated that she does not go out to the activities and stays in his room for meals by his own choice. On 4/17/26 at 12:45 PM, R64 stated that she can only get coffee during breakfast hours. R64 states that when she asks for coffee any other time of the day the staff report that it is only available at breakfast. 3. R66's face sheet documents an admission date of 2/6/19. R66's April Physician's Order sheet documents R66 has a regular diet ordered.On 4/16/26 at 2:00 PM, R66 who was alert to person, place and time, stated that he just eats what he gets because he didn't know there were other options to choose from. R66 stated that he does not go to the activities normally by his own choice. R66 stated that he prefers to stay in his room and do his own thing all day. 4. R22's face sheet documents an admission date of 6/16/25. R22's April Physician's Order sheet documents R22 has a regular diet orderedOn 4/16/26 at 2:30 PM, R22 who was alert to person, place and time, stated that he does not get choices on his meal options, he just gets what is served. R22 stated he does not get sheets to fill out the day prior to the meal to make his selections, other than he did yesterday for the first time and he did choose some of the alternates rather than the main choices and he liked that he had an option. On 4/16/26 at 10:00 AM, V18 (Dietary Manager) stated that the activities department is supposed to meet with the residents daily to review the menu and fill out the menu for the following day. This menu has the planned alternatives on the sheet. V18 stated that on Fridays then they fill it out for the weekend through Monday's breakfast. On 4/16/26 at 11:00 AM, V18 (Activities) stated that she fills out the menus with the residents during the day while doing activities. The meal substitutions policy with revision date of 12/2016 documents that appealing alternate options of similar nutritive value shall be available for all meals for residents who choose not to eat food that is initially served or who request a different meal choice. Alternates shall be offered to residents who refuse menu items. In cases where the menu item as well as the alternate is refused, staff shall investigate a reasonable solution within product availability.

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide Pneumococcal Immunizations for 4 (R18, R47, R62, and R64) of 9 residents reviewed for Immunizations in the sample of 51. The Findings Include1. R18's face sheet documents R18's date of birth as 10/22/1944 (over [AGE] years of age) and an admission date to the facility of 07/31/2019. The diagnoses listed include polyosteoarthritis, unspecified dementia, psychotic disorder with delusions, major depressive disorder, anxiety disorder, hypothyroidism, essential hypertension, and acute upper respiratory infection.R18's I-Care (Illinois Comprehensive Automated Immunization Registry Exchange) documented that R18 has not had any pneumonia vaccines.R18's vaccine consent release only dated year 2026, documented R18 agreed to the Pneumococcal vaccination.R18's progress note dated 03/20/2026 documented obtained consent for resident requesting pneumonia vaccination. Order put in to be administrated 03/26/2026. 2. R47's face sheet documents R47's date of birth as 11/07/1941 (over [AGE] years of age) and an admission date to the facility of 12/17/2025. The diagnoses listed include primary osteoarthritis, depression, anxiety, thrombocytopenia, peripheral vascular disease, chronic pain, essential hypertension, and overactive bladder.R47's I-Care documented R47 had pneumococcal polysaccharide on 10/21/2015 and Prevnar 13 on 10/21/2021.R47's vaccine consent and release only dated year 2026 documented R47 agreed to the pneumococcal vaccination.R47's progress note dated 03/20/2026 documented resident offered pneumonia vaccine and agreed, consent signed. Order put in for 03/24/2026. 3. R62's face sheet documented R62's date of birth as 03/26/1941 (over [AGE] years of age) and an admission date to the facility of 04/18/2018. The diagnoses listed include unspecified dementia, major depressive disorder, generalized anxiety disorder, delusional disorders, parkinsonism, gastro - esophageal reflux disease, and hyperlipidemia.R62's I-Care does not document that R62 has received a pneumococcal vaccination. R62's vaccine and consent release only dated year 2026 documented that R62 agreed to the pneumococcal vaccination.R62's progress note dated 03/20/2026 documented received written consent for a pneumococcal vaccine from resident. Order put in to be administered 03/24/2026. 4. R64's face sheet documented R64's date of birth as 07/21/1963 (over [AGE] years of age) and an admission date to the facility of 01/11/2024. The diagnoses listed include acute and chronic respiratory failure with hypoxia, heart failure, secondary pulmonary arterial hypertension, major depressive disorder, chronic obstructive pulmonary disease, and insomnia.R64's I-Care does not document that R64 has received a pneumococcal vaccination.R64'a vaccine and consent release only dated year 2026 documented that R64 agreed to the pneumococcal vaccination.R64's progress noted dated 03/20/2026 documented written consent for resident requesting pneumonia vaccine. Order put in for administration for 03/26/2026.On 04/16/2026 at 9:04 AM observation was made of the medication room. In the medication fridge there was a Prevnar 20 for R47 and R62. The order date on the vaccine was 03/20/2026. The medication fridge also contained a Prevnar 20 for R18 and R64. The order date on those vaccines was 03/23/2026. On 04/16/2026 at 12:20 P.M. V21 (Licensed Practical Nurse) stated the vaccines in the fridge, are for residents that do not have consents scanned into the chart and that is why those vaccines have not been given. V6 stated she believes those residents have consents now.On 04/16/2026 at 2:58 P.M. V2 (Director of Nursing) stated when the medical record employee quit, there was a pile of papers that need scanned into the chart that was not done. V2 stated the consents were obtained and a progress note was completed for the day that the consent was obtained. V2 stated the nurses would not give the Prevnar 20 until the consents were scanned into the chart. On 04/17/2026 at 12:10 P.M. V2 (Director of Nursing) stated she started at the facility on 03/09/2026. V2 stated she will be the person that will be responsible for vaccinations moving forward. V2 stated she just got access to I care so she can now see who has had what vaccine. V2 stated she has not had the time to look at vaccines to see who is up to date and who (continued on next page)

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needs vaccines. V2 stated she is not aware who is up to date on pneumonia vaccines and who needs them. V2 stated she did not know that there were vaccines in the medication fridge that needed to be given. V2 stated she will be calling the physician and getting a new order to give the pneumonia vaccines. V2 stated vaccines should be given with a consent, and an order per the policy.On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated it is her expectation that vaccines should be given when they are ordered. V1 stated the staff should follow the policy on vaccinations. V1 stated she is not a nurse and does not have access to the medication fridge, so she was not aware that there were vaccines that were not given. V1 stated she was not aware that the consents had been obtained but were not scanned in the computer. V1 stated she is not aware who was responsible for vaccines prior but the facility had completed an audit because she knew there were issues. Facility policy titled Pneumococcal Vaccine with a date of 02/11/2022 documented it is the policy of this facility that all residents are protected from incident of pneumonia by obtaining pneumococcal vaccines, if desired, per CDC guidelines. According to the Centers for Disease Control website, https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, the following recommendations were retrieved in part as of 8/21/25: Administer PCV15, PCV20, or PCV21 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine or those whose previous vaccination history is unknown. Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need.

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	145135	A. Building B. Wing	04/21/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to sign and complete an IDPH (Illinois Department of Public Health) Uniform Practitioner Order for Life Sustaining Treatment (POLST) form for 1 (R87) of 1 residents reviewed for Advanced Directives in the sample of 51. Findings included:R87's admission Record documented an admission date of 4/05/2026 and included diagnoses of unspecified dementia, unspecified severity, with anxiety, other chronic pain, cognitive communication deficit, pain, unspecified, edema, unspecified, and insomnia, unspecified.R87's Minimum Data Set (MDS) dated [DATE] documented under section A1600- admission Date of 4/5/2026.On 04/15/2026 at 12:40 PM, V12 (Licensed Practical Nurse/LPN) stated advanced directives are located on the residents medication administration sheet located in the residents electronic health record (EHR). V12 stated, R87 does not have a POLST form in his electronic health record and she is not aware of who inputs that information. On 4/15/2026 at 12:52 PM, V2 (Director of Nursing/DON) stated she does not handle the POLST documentation for residents, however they should have their POLST form located in their EHR under resident documents, POLST information. V2 stated, you should be able to observe the information under residents name in the EHR. On 4/15/2026 at 1:03 PM, V13 (Social Services Director/SSD) stated upon admission to the facility, she will complete the POLST form to send to the physician then scan it into the resident's EHR. V13 stated, she does have R87's POLST form, dated by family on 3/26/2026 with no physician signature. V13 stated, she is not sure how long of a time she had to get the POLST form completed, but she feels it is 48 hours. On 4/15/2026 at 1:10 PM, V1 (Administrator) stated V13 (SSD) should complete the POLST form, send it to the physician to be signed, and upload information into the residents EHR. V1 stated, this information should be completed within 24 hours of admission. R87's POLST form dated 3/26/2026 documented no signature by physician.The facility's Advance Directive Policy (revised October 7, 2025) documented under Policy Statement, advance directives will be respected in accordance with state law and facility policy. Under Policy Interpretation and Implementation, 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law.

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	145135	A. Building B. Wing	04/21/2026

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Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a clean homelike environment for 2 of 2 (R8 and R62) residents reviewed for cleanliness in a sample of 51. The Findings Include: 1. R8's admission Record documented an admission date of 6/03/2004 and included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R8's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99, which indicates severe cognitive impairment. Under section GG0120. Mobility Devices documented R6 used a wheelchair for mobility. R8's Care Plan documented a focus area of difficulty with communicating needs due to unclear speech and difficulty finding words to complete thoughts with interventions that included observing closely and anticipating needs as needed. On 04/14/2026 at 1:19 PM observed resident self-propelling in wheelchair to room. R8 was happy and pushed call light for assistance. Observed R8's wheelchair in disrepair including a bandage wrapped around the right and left side of the frame next to the end of the seat. Observed red sauce, old cheerios, hair and dirt on the right lower wheelchair frame. Observed R8's non-slip grip under cushion with food stains located on the outside of cushion. On 04/17/2026 at 12:20 PM Observed resident self-propelling in wheelchair to room. R8 was happy and pushed call light for assistance. Observed R8's wheelchair in disrepair including a bandage wrapped around the right and left side of the frame next to the end of the seat. Observed red sauce, old cheerios, hair and dirt on the right lower wheelchair frame. Observed R8's non-slip grip under cushion with food stains located on the outside of cushion. On 4/17/2025 at 12:22 PM, V23 (Certified Nurse Assistant/CNA) stated the night shift nursing staff is supposed to be cleaning the wheelchairs, however, it is not being done. V23 stated, she attempts to clean them during the daytime when she can. V23 stated, there is no documentation for R8's wheelchair being cleaned. V23 stated, she does not know why there is a bandage on R8's wheelchair. 2. On 4/14/26 at 1:30 PM, R62's bed frame was observed to be visibly soiled with dried food and spills. On 4/17/26 at 11:28 AM, R62's bed frame is still in the condition that was seen on 4/14/26. On 4/17/26 at 10:23 AM, V1 (Administrator) stated that R62 likes to eat and drink in his bed and he spills a lot of food and is a messy eater. V1 states that she will get someone in here to clean up the bed frame.

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	145135	A. Building B. Wing	04/21/2026

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Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the resident or the resident's representative of the transfer/discharge/bed hold in writing for 3 (R2, R6, and R7) of 3 residents reviewed for discharge notification/bed hold in the sample of 51. The Findings Include: 1. R6's admission Record documented an admission date of 10/01/2025 and included diagnoses of metabolic encephalopathy, acute kidney failure, unspecified, unspecified dementia, unspecified severity, with other behavioral disturbance, type 2 diabetes mellitus without complications, anxiety disorder, unspecified, depression, unspecified, mood disorder due to known physiological condition with major depressive-like episode. R6's Progress Note by V12 (LPN/Licensed Practical Nurse) dated 4/1/2026 at 12:40 PM documented resident returned from the local emergency by ambulance at 12:30 PM. R6's local emergency room After Summary visit dated 4/1/2026 documented under Chief Complaint: R6 had been brought into the emergency room department from the facility. R6 had been given her nighttime medications of trazodone and rosuvastatin in the morning instead. During this survey the facility could not produce evidence a Bed Hold was provided to the resident or resident's representative for R6's emergency room visit on 4/1/2026. 2. R2's face sheet documents an admission date of 11/22/2023. This same document includes the following diagnosis: unspecified dementia, major depressive disorder, anxiety, and visual hallucinations. R2's Progress notes on 12/5/25 document R2 was sent to the emergency room after a fall with pain noted to her joint area. During this survey the facility could not produce evidence a Bed Hold was provided to the resident or resident's representative for R2's emergency room visit on 12/5/25. On 4/16/26 at 2:30 PM, V9 (Behavioral Health Case Manager) stated that the resident families are notified by the facility via telephone call and the transfer papers are sent with the resident in the ambulance. V9 stated that the bed hold and transfer forms are not mailed to the family/Power of Attorney. 3. R7's face sheet documented R7 was admitted to the facility on [DATE]. Diagnoses listed include transient cerebral ischemic attack, paranoid schizophrenia, unspecified psychosis, type 2 diabetes mellitus, chronic obstructive pulmonary disease, anxiety disorder, essential hypertension, and gastro esophageal reflux disease. R7's progress note dated 04/13/2026 with a time of 11:53 A.M. authored by V25 (Registered Nurse) documented that R7 was sent to the hospital as R7 was not responsive to verbal stimuli. R7's progress note dated 04/13/2026 with a time of 5:49 P.M. authored by V25 documented that R7 was admitted to the local hospital with a diagnosis of acute encephalopathy and acute hypoxic (continued on next page)

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	145135	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respiratory failure. During this survey the facility could not produce evidence a Bed Hold was provided to the resident or resident's representative for R7's hospital visit on 4/13/2026. On 04/16/2026 at 10:15 AM, V1 (Administrator) stated social service director used to do bed holds and transfer documents. V1 stated last week when R7 was discharged to the hospital she realized that no one had been doing the forms. V1 stated she knows it is charted that he had one, but R7 was never given one. V1 stated she plans to start educating the staff on bed hold / transfer notifications because they should be completed by the nurse that is sending them to the hospital. Facility policy titled Notice of a Transfer and or Discharge dated 11/5/2025 documented 2. The written notice (Involuntary discharge form and/or Necessity of Transfer and bedhold policy form) to the resident and/or representative (Sponsor) will include the following: a. the reason for the transfer or discharge, b. the effective date of the transfer or discharge, c. the specific location to which the resident is being transferred or discharged .

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on interview and record review the facility failed to complete a comprehensive assessment annually and submit it timely for 1 (R73) of 1 resident reviewed for comprehensive assessments in the sample of 51. The Findings Include:R73's face sheet documents an admission date to the facility of 03/03/2025. The diagnoses listed include Alzheimer's disease, unspecified dementia, chronic kidney disease stage 4, paroxysmal atrial fibrillation, unspecified systolic heart failure, and essential hypertension. A final validation report dated 04/14/2026, provided by V1 (administrator) documents that R73's annual MDS (Minimum Data Set) had a target/ due date of 03/04/2026 and was not completed until 4/14/26. The same document had a warning message of assessment completed late: more than 14 days after the assessment reference date.On 04/15/2026 at 12:33 P.M. V7 (Regional Nurse) stated that the facility does not have an MDS nurse. V7 stated that there is a regional nurse that is trying to complete all the MDS's. On 04/17/2026 at 12:23 P.M. V1 (Administrator) stated V26 (former employee) quit without notice on 03/24/2026. V1 stated she was not aware that V26 was behind on completing MDS assessments.

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	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to refer a resident for a PASARR (Preadmission Screening and Resident Review) screening following the addition of a diagnosis of Schizoaffective Disorder for one resident (R28) of two residents reviewed for PASARR screening in the sample of 51.Findings include:R28's Face Sheet documented an admission Date of 10/31/17 and listed among the diagnoses was Schizoaffective Disorder Depressive Type with an effective date of 9/7/24. R28's Minimum Data Set, dated [DATE] documented that R28 has moderate deficits in cognition. R28's Care Plan dated 2/16/26 documented a problem area, Resident receives antidepressant medication for appetite and Schizoaffective Disorder, Depressive Type.R28's Illinois Department of Healthcare and Family Services Interagency Certification of Screening Results document dated 10/31/17 documented, Screening indicated nursing facility services are appropriate. Based on all information and data available to me for this person, there is reasonable basis for suspecting MI (Mental Illness) or DD (Developmental Disorder): No. There was no documentation to indicate R28 was referred for reevaluation after the 9/7/24 addition of the Schizoaffective Disorder diagnosis.On 04/16/2026 at 10:57am, V9, Behavioral Health Case Manager, stated at her previous job in community mental health, she had provided case management services for R28, who had a long history of mental illness. V9 stated when R28 was first admitted to the facility, it was for skilled nursing care, not behavioral health services, but she was later moved onto the behavioral health unit. V9 stated she is not sure why upon initial admission the screener would not have had access to R28's history and realized she had history of mental illness. V9 stated she is not sure why the diagnosis was not added until 9/7/24.On 04/17/2026 at 9:14am, V1, Administrator, stated there may be other residents in the facility who need to be rescreened for PASARR, she stated she will do an audit and have these residents rescreened. A Resident Assessment: Coordination with PASARR Program Policy dated October 2017 documented, 6. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual authority for a level 2 resident review.

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	145135	A. Building B. Wing	04/21/2026

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to follow physician orders for dating/labeling when changing oxygen tubing and humidifier bottles for 3 of 3 (R64, R66 and R80) residents reviewed for oxygen tubing in a sample 51. The Findings Include: 1. R66's face sheet documents an admission date of 2/6/19. This same document includes the following diagnosis: chronic obstructive pulmonary disease and centrilobular emphysema. R66's April physician orders include an order to change oxygen tubing and humidifier bottle weekly, initial and date once a day on Saturday. R66's Medication Administration Report (MAR) dated 3/21/26-4/20/26 documents that R66's oxygen tubing was changed every Saturday. On 4/15/26 at 1:30 PM, R66 who was alert to person, place and time stated that he does not know when they change his tubing or how often it happens. R66 stated he cannot remember when they did it last. On 4/15/26 at 1:30 PM, R66's oxygen tubing was observed to have a label without a time with a date of 3/14. The humidifier bottle was not labeled with a date or time. On 4/16/26 at 11:00 AM, V7(Regional Nurse) confirmed that the date on R66's oxygen tubing is 3/14 and that it should be changed out weekly as the order states. On 4/16/26 at 9:50 AM, V6 (Licensed Practical Nursing/LPN) stated that nursing is supposed to date and label the oxygen tubing when it is changed weekly. On 4/16/26 at 9:55AM, V7 (Regional Clinical) stated that the company that they use for the concentrators comes and services/switches out the equipment as needed. V7 also confirmed that the tubing and bottle should be dated and labeled as the order is written when changed weekly. 2. R64's face sheet documents an admission date of 1/11/2024 and includes the following diagnosis: acute and chronic respiratory failure with hypoxia, secondary pulmonary arterial hypertension, and Chronic Obstructive Pulmonary Disorder (COPD). R64's physician orders for April 2026 includes an order to change oxygen tubing and humidifier bottle weekly and initial and date once a day on Saturday. R64's MAR dated 4/1/26-4/20/26 documents that R64's oxygen tubing and humidifier bottle was changed on Saturdays. On 4/14/26 at 11:30 AM, R64 who was alert to person, place and time, stated that her tubing does not getting changed as regular as it used to. R64 stated that there is one nurse that will do it if she is working, but otherwise it never gets changed.On 4/14/26 at 1:09pm, on 4/15/26 at 2:12pm, on 4/16/26 at 9:50 am and on 4/17/26 at 9:25am R64's tubing and humidifier bottle did not have a date/time placed on the tubing or humidifier bottle to indicate when it was last changed. 3. R80's face sheet documents an admit date to the facility of 2/20/23. This same document includes the following diagnosis: Chronic respiratory failure, and anxiety. R80's April physician order sheet includes an order to change oxygen tubing and humidifier bottle weekly and initial and date once a day on Saturday. On 4/14/26 at 11:30 AM, R80 who was alert to person, place and time, stated he has no idea the last time his oxygen tubing was changed. At this time R80's oxygen tubing and humidifier bottle were not labeled with the date and time of the last change. R80's MAR dated 3/21/26-4/20/26 documents that the oxygen tubing and humidifier bottle was changed on Saturdays. On 4/17/26 at 11:30 AM, V1 (Administrator) stated that the oxygen tubing should be labeled with date and time of exchange as the order states.The Oxygen Administration policy with a revision date of 2012 documents in part: The purpose of this procedure is to provide guidelines for safe oxygen administration .tubing is to be changed monthly and as needed if soiled or otherwise compromised .