STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145571	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Health & Rehab Ctr	One Perryman Street Lebanon, IL 62254

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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 ensure residents were safely transferred via mechanical lift, failed to ensure fall interventions were in place according to resident Care Plans, and failed to provide an appropriate shower chair resulting in a resident to sustain a fall for 4 of 7 (R22,R28, R54, R69) residents reviewed for accidents in the sample of 52. Findings Include:1.R28's admission Record print date of 3/11/26 documents R28 has diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, COPD (chronic obstructive disease), chronic atrial fibrillation, hypertension, polyneuropathy, depression, and anxiety. R28's MDS (Minimum Data Set) dated 1/19/26 documents R28 is cognitively intact and requires partial/moderate assistance with wheelchair transfers and showers. R28's undated Care Plan documents R28 is at risk for falls related to left hemiparesis, difficulty walking, and lack of coordination with a goal of minimizing risks for falls. R28's fall occurrence note dated 1/12/26 at 3:41 PM documents incident description: resident slipped in shower room. Did not hit head. Fall was witnessed by staff. Resident evaluated and placed in w/c (wheelchair) and dressed. Resident states no discomfort or pain. Resident statement on what was being attempted when fall occurred in shower room, wet floor, wet chair, wet w/c. Resident description of fall: slipped in shower. Date/time of incident: 1/12/26 at 3:15 PM. Resident is alert. R28's fall report dated 1/12/26 documents resident slipped and fell in the shower, did not hit head. Witnessed by staff. Resident description: Slipped in shower. The facility's IDT (Interdisciplinary Team) note dated 1/12/26 documents resident noted on the floor in the shower room. RCA (root cause analysis): Resident slipped on the floor when showering. Intervention: Staff educated to utilize accessible shower chair for this resident to prevent standing during showering. On 3/11/26 at 8:33 AM R28 stated when she fell in the shower room the CNA (Certified Nursing Assistant) did not place a gait belt around her, transferred her onto a small shower chair, and the shower chair moved out from under her during the transfer resulting in her falling onto the shower floor. R28 stated she hurt her side, it was bruised, but she did not go to the hospital. R28 stated the CNAs still do not place a gait belt around her when she showers although they do use a bigger shower chair now. On 3/11/26 at 10:12 AM V20 (MDS Nurse) stated the intervention for R28's fall on 1/12/28 was staff (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	educated to utilize accessible shower chair for resident to prevent standing during shower. Surveyor asked what kind of chair R28 was placed on and V20 stated she did not know. On 3/11/26 at 10:46 AM V1 (Administrator) stated R28's fall intervention was to use a shower chair rather than the shower bench. V1 stated she expects CNAs to follow the facility policy for transfers. On 3/11/26 at 11:10 AM V21 (CNA) stated she was with R28 on 1/12/26 when R28 fell in the shower. V21 stated she had R28 on the small shower chair, the shower chair does not have an opening in the seat so she had R28 stand up so she could clean her buttocks and when R28 stood up, the shower chair moved back a bit so when R28 sat back down she missed the chair and fell. Surveyor asked why V21 used that shower chair and V21 stated the other kind was not available. Surveyor asked V21 if R28 had a gait belt on and V21 replied no. Surveyor then asked if the shower chair in use at the time of the fall had breaks on it and V21 replied no. 2. R54's admission Record, print date of 3/11/26, documents R54 has diagnoses including facial weakness following cerebral infarction, type 2 diabetes mellitus with diabetic chronic kidney disease, dysphagia following cerebral infarction, hypertension, obstructive and reflux uropathy, and atherosclerosis. R54's MDS dated [DATE] documents R54 is moderately cognitively impaired and requires partial/moderate assistance with transfers. R54's Fall Risk Evaluation dated 2/17/26 documents R54 is at high risk for falling. R54's undated Care Plan documents R54 is at risk for fall related to generalized weakness, lack of coordination, and difficulty walking. Interventions include non-skid mat to wheelchair. R54's progress note dated 2/16/26 at 2:16 PM documents Incident Description: observed on floor in room. Resident statement on what was attempted when fall occurred unsteady gait, requires assistance with transfers. Resident Description of Fall: I was trying to get to the bathroom and slid out of my chair. R54's fall report dated 2/16/26 documents resident observed on floor in room. Resident description: I was trying to go to the bathroom and slid out of my chair. IDT (Interdisciplinary Team) note: Resident observed sitting on the floor next to his bed. RCA (Root Cause Analysis): Resident slipped from wheelchair. Intervention: Non-skid mat to wheelchair. On 3/11/26 at 11:43 AM Surveyor observed V15 (CNA) transfer R54 from his bed to his wheelchair. No non-skid mat was observed on R54's wheelchair seat. On 3/11/26 at 12:42 PM V20 (MDS Nurse) stated the intervention for R54's fall on 2/16/26 was a non-skid mat in his wheelchair. On 3/11/26 at 1:06 PM V14 (Registered Nurse/RN) checked R54's wheelchair along with Surveyor and V14 confirmed R54 did not have a non-skid mat in his wheelchair nor anywhere in his room. 3. R69's admission Record with print date of 3/11/26 documents R69 has diagnoses including metabolic encephalopathy, pulmonary fibrosis, acute pulmonary edema, type 2 diabetes mellitus with chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting left (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	non-dominant side, chronic respiratory failure with hypoxia, emphysema, congestive heart failure, atherosclerosis, pulmonary hypertension, cognitive communication deficit, difficulty in walking and repeated falls. R69's MDS dated [DATE] documents R69 is moderately cognitively impaired and is dependent on staff for transfers and all mobility. On 3/9/26 at 9:25 AM V16 (CNA) and V15 (CNA) were observed as they transferred R59 from her bed and into her wheelchair via a mechanical lift. As R69 was lifted into the air via the mechanical lift sling the battery to the lift stopped functioning resulting in the legs of the lift to be stuck in the closed position and R69 was stuck in the air. V16 stated to V15 we will have to transfer her sideways. V15 then took her hands off R69 and the transfer sling leaving R69 hanging from the lift without any staff support/touch. V15 then moved R69's wheelchair and placed it sideways against the lift. V16 pressed the emergency release button on the mechanical lift. As R69 was being lowered into the wheelchair V15 raised the wheelchair's front tires up and off the floor due to the mechanical lift legs being stuck in the closed position. On 3/12/26 at 10:03 AM V16 (CNA) stated during a mechanical lift transfer one CNA operates the lift and the other CNA guides the resident in the lift sling. Surveyor asked V16 if it is acceptable for a staff member to ever take their hands off the lift sling when the resident is suspended in the air and V16 replied no, there should always be hands on the sling/resident. On 3/11/26 at 3:57 PM V1 (Administrator) stated she expects facility staff to follow the facility's policies. On 3/12/26 at 11:08 AM V20 (MDS Nurse) stated she would expect resident fall interventions to be in place as documented in resident Care Plans. V20 also stated there should always be 2 CNAs present when transferring residents with a mechanical lift and she would expect one of the CNAs to always keep their hands on the resident/sling during the transfer. 4. R22's Face Sheet, print date of 03/12/25, documents R22 has diagnoses of but not limited to dementia, Chronic Obstructive Pulmonary Disease (COPD), Type II diabetes mellitus (DM), and protein-calorie malnutrition. R22's MDS, documents R22 is moderately cognitively impaired, she is dependent on staff for all her ADLs, and she is incontinent of bowel and bladder. R22's Care Plan, admission date of 08/23/23, documents R22 is at risk for falls r/t (related to) dementia, COPD, PVD (Peripheral Vascular Disease), MI (Myocardial Infarction), presence of right artificial hip joint, osteoarthritis, pain in right and left knee. Interventions include but are not limited to fall mats and keep bed in low position. On 03/09/2026 at 09:22 AM, R22 is lying in her bed with her head elevated. Fall mat seen folded up and sitting up by the head of the bed in between the bed and the wall with the window. On 03/10/2026 at 11:44 AM, R22 is lying in bed facing towards the window. R22's fall mat was seen folded up and standing up by the head of the bed. On 03/12/25 at 8:30 AM, V1 (Administrator) stated they do not have a fall prevention policy of any (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kind but there is a statement at the end of one of the policies she has already given us. The Facility's policy Transfer Policy, revision date 05/19/22, documents Policy: To promote safe transfer for the residents, as well as the staff. Gait belts, Hoyer lifts, and/or sit to stand lifts will be used, unless otherwise specified. The facility's policy Accidents and Incidents, revised date 09/07/23, documents 5. The Interdisciplinary Team (IDT) will conduct a thorough investigation of the accident/incident. Findings of the investigation, including root cause of the accident/incident and appropriate interventions will be indicated in the incident report and implemented. 6. The MDS (Minimum Data Set) nurse shall update the care plan with implemented interventions and communicate interventions with line staff.

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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 timely and complete incontinent care for 2 of 8 residents (R93, R96) reviewed for incontinent care in the sample of 52.The findings include: 1. R93's admission Record, dated 3/9/26, documents R93 was originally admitted to the facility on [DATE] with diagnosis of Dementia, Cirrhosis of liver, Type 2 DM, Spondylopathies, Chronic Kidney Disease (CKD)-stage 3, HTN, Polyneuropathy, Uropathy, Anemia, Major depressive disorder, COVID, Osteoarthritis, and Neuralgia/Neuritis. R93's Care Plan, dated 3/3/26, documents R6 has an ADL (Activities of Daily Living) self-care performance deficit. Interventions: Bathing: Uses adaptive equipment Shower Chair/Bed with total assist but R93 prefers to have bed baths, Personal Hygiene: 1 person assist. 1/6/26: R93 is unable to dress or groom independently related to: Polyneuropathy, Lumbar Disc Degeneration, Polyarthritis. 2/6/26: R93 is at risk for impaired skin integrity related to confined to a bed all or most of the time, decreased sensory perceptions, dementia, depression, history of poor nutritional intake, history of pressure ulcers, impaired cognition, incontinent of bladder, incontinent of bowel, poor nutritional intake. Interventions: Notify nurse of any new areas of skin, breakdown noted during bathing or daily care, provide incontinence care PRN. 3/3/26: R93 is at risk for fluid volume deficit related to diuretic medication. R93 has episodes of bladder and bowel incontinence. Interventions: Provide disposable incontinence products, provide peri care after each incontinent episode; apply house barrier after incontinence care as needed, Report any redness, irritation, skin excoriation/breakdown peri-area. R93's Minimum Data Set, (MDS), dated [DATE], documents R93 has a moderate cognitive impairment and is dependent on staff for toileting and dressing. R93 requires substantial/maximal assistance from staff for bathing, with partial/moderate assistance from staff for personal hygiene. R93 is always incontinent of both bowel and bladder. On 3/9/26 at 10:10 AM, R93 seen getting transferred from bed to her recliner by V23 (Certified Nursing Assistant/CNA) and V24 (CNA). R93's bed linen were saturated in urine with a large wet spot noticed in middle of her bed where her buttocks would be sitting and a strong smell of urine. On 3/10/26 at 8:20 AM, R93 seen in bed eating breakfast, R93 stated she has not been cleaned up yet, they woke her up for breakfast and no one provided incontinent care, and she is currently wet from overnight. On 3/10/26 at 9:45 AM, R93 still lying in bed, stated staff picked up her breakfast tray, stated she is still wet and has not been checked or cleaned yet. On 3/10/26 at 10:25 AM, V9 (CNA) stated This is the first time we are getting R93 out of bed this morning. On 3/10/26 at 10:30 AM, V9 (CNA) and V10 (CNA) performed peri-care on R93, and upon removing the incontinence brief, it appeared to be saturated in urine. On 3/12/26 at 10:50 AM, V32 (CNA) stated I check on the residents every two hours. I come on at (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:30 AM and immediately start checking the residents. Those residents who are on the restorative program, we try to get up first and get them to the dining room. Then we go back and get the other residents up. We do incontinence care when we get them up. On 3/12/26 at 10:52 AM, V25 (CNA) stated I check my residents every two hours, and probably even more because I am always up and down the hall all day long and stopping in resident rooms to check on them. We start at 6:30 AM and start getting residents up and do incontinent care at that time. All residents are checked from 6:30 AM until lunch for incontinence. On 3/12/26 at 11:55 AM, V1 (Administrator) stated I would expect the staff to follow policies. 2. R96's Care Plan, dated 1/12/2026, documents that R96 has episodes of incontinence related to decreased sensation to void, impaired mobility. It also documents Check and change every 2 hours and PRN (as needed). R96's MDS, dated [DATE], documents that R96 is cognitively intact, always incontinent of bowel and bladder, and dependent on staff for toileting. On 3/10/2026 at 9:41 AM observed V25 (CNA) and V26 (CNA) perform incontinent care on R96. R96 was incontinent of urine and bowel. V25 and V26 assisted R96 on her left side, using a wet washcloth V25 then cleansed R96's anal area and part of R96's buttocks. V25 and V26 then assisted R96 on to her back onto visual stool soiled bath blanket. Using a wet washcloth V25 then cleansed R96's peri area and inner thigh. With each swipe allowing R96's stump to move about in stool. V25 then touched R96's pubis area with soiled gloves leaving small amount of stool on pubis area. V25 and V26 then turned R96 onto her left side and cleansed the anus and inner thighs. The facility's Incontinent Care policy, dated 5/16/2022, documents that Purpose: To provide guidelines to all nursing staff for providing proper incontinence care in order to keep skin clean, dry, free of irritation and odor. Policy: ALL incontinent residents will receive incontinence care in order to keep skin clean, dry and free of irritation and/or odor. Incontinence care will be provided as required. Procedure 8. Wash all soiled skin areas and dry very well, especially between skin folds; changing gloves and performing hand hygiene as required to prevent cross-contamination.