STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146096	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Health & Rehab Cntr	413 Ridge Lane Oblong, IL 62449

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on interview and record review the facility failed to notify the physician prior to a residents discharge for 1 of 3 residents (R1) reviewed for discharge planning in a sample of 5. Findings Include: Review of R1's Admission Record documented R1's initial admitted to the facility as 08/02/2024 . The same document lists diagnoses for R1 as the following: other acute osteomyelitis, left foot and ankle, essential hypertension, alcohol use, and patient's other noncompliance with medication regimen. R1's Minimum Data Set (MDS) with an Assessment Reference Date of 08/09/2024 documented a Brief Interview for Mental Status Score of 15, indicating R1 is cognitively intact. A Progress Note dated 09/14/2024 with a time of 12:24 P.M. authored by V5 (Registered Nurse) documented R1 left the facility at 12:20 P.M., belongings, meds and narcotics sent with R1. R1 was educated on care of his wound and given his follow up appointment schedule, R1 voiced understanding. R1 left the facility via private car with friend. A form tiled (name of company)-Discharge Plan and Instruction with a date of 09/12/2024 documented that R1 had follow up appointments with the locations, date and times. The form goes on to document no home health care services were set up, no medical equipment needed, and medications were discussed with R1. R1's Order Summary Report with a Active Orders as of 09/14/2024 printed on 10/30/2024, documented an order dated 08/02/2024, for PICC (Peripherally Inserted Central Catheter) to be used for antibiotic use. The same document documented an order dated 08/02/2024, for Ertapenem 1 GM(Gram) intravenously every 24 hours for infection for 6 weeks. There were no orders documented on R1's Order Summary Report from V7 regarding R1's discharge or follow up care for the management of the PICC line. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan with and initiation date of 08/17/2024 has a Focus area of: Potential for infection related to IV (intravenous) use of PICC Line. The same document listed Goal: Will have no signs and symptoms of IV related complications. The same document goes on to list the interventions as administer medications as ordered, change catheter site dressing as required, change IV tubing as ordered, change sterile cap as ordered, labs as ordered, and monitor the site for redness, swelling, and or drainage. The same document went on to list a Focus Area of: The resident wishes to return/be discharged to home. The Goal is listed as: The resident will communicate an understanding of the discharge plan and describe the desired outcome. The same document went on to list the interventions as: encourage the resident to discuss feelings and concerns with discharge, evaluate the residents motivation to return to the community, make arrangements with required community resources to support independence post discharge, and prepare and give the resident contact numbers for all community referrals. On 10/30/2024 at 9:40 A.M. V3 (Hospital Social Service Worker) stated that R1 presented to the emergency roiagnom on [DATE] with the same PICC line in that was supposed to be taken out before he left the facility. V3 stated that R1 was discharged from the hospital and admitted to the facility on [DATE] for IV antibiotics. R1 was supposed to be discharged from the facility with the PICC line discontinued due to R1 having a history of being a known drug user and homeless. V3 stated that according to the discharge instructions that the facility was given from the hospital when R1 was admitted to the facility, R1 was to complete his antibiotics on 09/12/2024. V3 stated that R1 had an infection of his foot that required weeks of IV (Intravenous) antibiotics. V3 stated that once R1 was discharged from the facility there was no one caring for the PICC line and that R1 was living off of friends' couches. V3 stated that R1 told the emergency room staff that he was tying a belt around the PICC line to keep it from hanging down. V3 stated that once R1 was readmitted to the hospital on 10/20/2024, they completed a culture of his foot where the wound was and placed a new PICC line for further treatment with IV antibiotics. V3 stated that R1 was discharged to another facility for further treatment. Review of Progress Note from local hospital dated 10/21/2024 timed 10:08 P.M. authored by V4 (Hospital Emergency Department Physician) documented Patient reportedly left the nursing home with PICC line, possibly AMA case management consulted and will be investigating. On 10/30/2024 at 1:53 P.M., an attempt was made to contact R1 at the number provided on R1's facility Admission Record and the number is not a working phone number. On 10/30/2024 at 12:13 P.M. V1 (Administrator) stated that R1 was in the facility with a PICC line to receive IV antibiotics related to an infection he had in his foot. V1 stated that R1 was reported to be homeless before coming to the facility. V1 stated that the local hospital had called on 10/23/2024 to ask questions about R1. V1 stated that she verified to the hospital that R1 had completed his antibiotic and she believed that his PICC line was taken out before he was discharged . V1 then stated that she verified with V2 (Director of Nursing) if the PICC line was removed before discharge. V1 did state that the hospital asked her if R1's discharge was planned and V1 stated that she explained the process to the case manager at the hospital. V1 stated that she verified to the hospital that R1 had completed his antibiotic and she believed that his PICC line was taken out before he was discharged . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 12:40 P.M. V2 (Director of Nursing) stated that R1 was at the facility for IV antibiotics related to osteomyelitis of his foot. V2 stated that he was supposed to be discharged after his last dose of antibiotics, but his ride couldn't come get him for a day or two. V2 stated that the plan was for R1 to return to his girlfriend's house after antibiotics were completed. V2 stated that R1 was sent home with medications and dressing supplies so he could do the dressings on his foot. R1 was also sent home with all of his medical follow up appointments. V2 stated that she was pretty sure the PICC line was taken out on the day the antibiotics were completed. V2 stated R1's last dose of antibiotics would have been 09/12/2024. V2 stated that it was her understanding that the PICC line was discontinued before R1 was discharged . On 10/30/2024 at 1:30 P.M. V5 (Registered Nurse) stated she was R1's nurse the day of discharge. V5 stated that she went over in length the importance of following up with all of his medical appointments when he is discharged . V5 stated that she is not sure if R1 still had his PICC line when he was discharged . V5 stated she did not do a skin check like you would on admission. V5 stated that she really did not know one way or another if R1 still had his PICC line and she can't really answer the question. V5 stated that she did not call the physician for discharge orders because she just thought they were already on the chart. V5 stated that she did not look to see if there were orders or not. On 10/30/2024 at 2:11 P.M. V6 (Registered Nurse) stated that she gave R1 his last dose of IV antibiotic on 09/12/2024. V6 stated she did not pull the PICC line out at that time. V6 stated she was off the next two days and did not take care of R1 anymore after 09/12/2024. On 10/31/2024 at 9:20 A.M. V1 stated she cannot find documentation in the chart for R1 to be discharged or for the PICC line to be removed. V1 stated that she is not sure why there is not an order in the electronic medical record for R1 to be discharged . V1 stated that R1's discharge was planned. V1 stated that all staff and V7 (Medical Doctor) was aware that R1 was going to leave as soon as his antibiotics were completed. V1 stated that R1 was given (company name)- Discharge Plan and Instructions form as well as a current medication list. On 10/31/2024 at 10:22 A.M. V7 (Medical Director) stated that she saw R1 on 09/04/2024 at the facility. V7 stated that she was made aware on 09/04/2024 by R1 and the facility that R1 wanted to be discharged after he completed his IV antibiotics. V7 stated there was no direct communication with the facility to her office about R1 going home. V7 stated that she did not give orders to the facility for R1 to be discharged . V7 stated that she has an office nurse who is responsible for her facility patients and the nurse was not made aware that the facility needed discharge orders. V7 stated that she would have expected the facility to discontinue R1's PICC line prior to him being discharged . V7 stated that it is standard routine care to discontinue a PICC line once the course of IV antibiotics were completed. On 10/31/2024 at 10:37 A.M. V2 (Director of Nursing) stated that it is her expectation for the nursing staff obtain discharge orders prior to discharge. V2 also stated that it is her expectation for PICC lines to be discontinued before discharge. V2 stated that there should be orders for these in the electronic medical record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Discharge / Transfer Policy with a revision date of 08/15/2022 documented under the section titled purpose, 1. When the facility transfers or discharges resident under any circumstances, appropriate documentation shall be made in the resident's clinical record. The attending physician shall give orders for the transfer / discharge. 3. A written or telephone order is required from the attending physician for the transfer or discharge of a resident except in emergency situations.