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	01/07/2025

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

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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 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** 32619 Based on interview and record review, the facility failed to notify a residents POA (Power of Attorney) of a change in condition for 1 of 3 residents (R1) reviewed for POA notification in the sample of 7. Findings include: R1's Admission Record documented an initial admitted [DATE] and a readmitted [DATE], and listed diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side, Type 2 Diabetes, Chronic Kidney Disease Stage 4 (Severe), Morbid Obesity, Epilepsy, and Aphasia. The same Admission Record identified V4 (family member) as R1's POA. R1's Wound Assessment and Plan Notes, authored by V6, Wound Care Nurse Practitioner, documented the following: 12/1/24: Wound location: Bilateral Buttocks, MASD (Moisture Associated Skin Damage) Wound onset date, 11/28/24. Irritant Contact Dermatitis due to dual incontinence. Coccyx, pressure injury, stage 3. Wound onset date 11/28/24. 12/10/24:Wound location: Sacrum, pressure injury, stage 3. Declined. Wound onset date 11/28/24. Location changed (from Coccyx) to more accurately reflect current wound. Wound location: Bilateral Buttocks: Healed. Location: Left Ischium, pressure injury, stage 2. Onset date 12/10/24. Wound location: Right Ischium, pressure injury, stage 3. Onset date 12/10/24. R1's Nurses Notes for November and December 2024 contained no documentation to indicate V4 was notified of R1's pressure ulcers. On 12/26/24 at 9:20am, V4, R1's Power of Attorney, stated on 12/11/24, V2, Director of Nurses, called V4 to state R1 had recently developed pressure areas, had experienced a deterioration in status, and the facility was sending R1 to hospital for treatment of a UTI (Urinary Tract Infection). V4 stated this was the first she had heard of R1 having pressure ulcers. On 1/2/25 at 2:25pm, V2 stated she believes that on the 4th or 5th of December, she had a conversation with V4 about R1 having developed pressure wounds. V2 stated apparently she did not document the conversation. (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	On 1/3/25 at 11:05am, V6 (Wound Care Nurse Practitioner) stated she generally relies on facility nursing staff to communicate with resident's families. V6 stated she did not speak with V4 about R1's pressure ulcers. The facility policy titled Change of Condition Protocol (revision date 1/23/23) documents 1. The interdisciplinary team, with the assistance of the physician, will help identify individuals with a significant risk for having acute changes of condition during their stay .11. As needed, the physician will discuss with the staff and resident/patient and/or family the pros and cons of diagnosing and managing the situation in the facility or the need for hospitalization . a. Many acute changes of condition can be managed effectively in nursing facilities with outcomes that are comparable to those of hospitalization . b. This discussion should consider the patient's overall condition, prognosis, and wishes (either direct or as conveyed by a substitute decision-maker).

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to provide incontinence care and timely toileting assistance for dependent residents for 2 of 7 residents (R1, R7) reviewed for ADL (Activities of Daily Living) care in the sample of seven. Findings include: 1. R1's Admission Record documented an initial admitted [DATE] and a readmitted [DATE]. Documented diagnoses include: Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side, Type 2 Diabetes, Chronic Kidney Disease Stage 4 (Severe), Morbid Obesity, Epilepsy, and Aphasia. R1's 12/11/24 Braden Scale for Predicting Pressure Ulcer Risk documented a score of 11, indicating R1 is at high risk for the development of pressure ulcers. R1's Minimum Data Set, dated dated dated [DATE] documented that R1 is severely cognitively impaired to the extent that a Brief Mental Status Score could not be performed, required substantial/maximal staff assistance for bed mobility, totally dependent on staff for transfers, and is always incontinent of bladder and bowel. R1's Care Plan dated 12/8/24 documents a Focus area of Potential for impaired skin integrity related to: Cognitive deficits, Decreased sensation, PVD (Peripheral Vascular Disease), DM (Diabetes Mellitus), hemiplegia right side, Impaired mobility, Incontinence. Documented interventions include Monitor Incontinence and provide pericare. The same Care Plan also documents a Focus area of (R1) has Self-Care Deficit As Evidenced by: Needs extensive assistance with ADL's related to impaired mobility, CVA, and Hemiplegia right dominate side. Documented interventions include: Bed Mobility - Assist to turn & reposition every 2 hours in bed & wheelchair, two person assist for pulling resident up in bed; may require one or two person assist for repositioning in bed depending on resident condition, and transfer: Mechanical Lift required. On 12/26/24 at 9:20am, V4, R1's Power of Attorney, stated V4 believed R1 developed pressure wounds due to not being repositioned and changed often enough, based on V4's history of working many years as a CNA (Certified Nursing Assistant). V4 stated as an example, V4 informed staff she wanted R1 get up to the wheelchair for meals, but when V4 visited, R1 often ate meals in bed. V4 stated staff told V4 that R1, Was a fall risk, had to be transferred with a mechanical lift, and they did not have enough staff to be able to supervise her while up. V4 stated she felt the facility was leaving R1 in bed all day for staff convenience. On 12/27/24 at 9:35am, V9, CNA, stated she primarily works the 6am to 6pm shift. V9 stated incontinent residents on the 6:00pm to 6:00am shift are not being changed and repositioned often enough. V9 stated most mornings when V9 arrives, including the morning of 12/27/24, incontinent, confused residents are urine soaked, with dried brown rings on bed linens, and dried feces. On 12/27/24 at 10:15am, V8, CNA, stated she primarily works the 6am to 6pm shift. V8 stated the facility definitely does not have enough CNAs on the 6pm to 6am shift. V8 stated when she begins her shift at 6:00am, confused incontinent residents are frequently urine soaked, with brown rings on linens, and dried feces. V8 stated R1 was always incontinent of both bowel and bladder and was unable to reposition herself. When asked about R1 developing pressure wounds, V8 stated, She probably got them from not being turned and changed enough. V8 stated in regard to R1, They just tried to turn her as best they could when they remembered and tried to keep her clean and dry. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 11:40am, V12, CNA, stated she generally works the 6am shift but has also worked the 6pm shift as well. V12 stated both shifts are often short of CNAs. V12 stated when she started her shift that morning (1/2/25), several incontinent residents were soaked with urine and had odor and brown rings on linens due to the 6:00pm shift not changing them. V12 stated, There are definitely issues with people not getting turned and changed every 2 hours. V12 stated on the 6:00pm shift, They don't do bed checks like they are supposed to. Everybody is in bed by 8:00pm or 9:00pm, then they are to do bed checks at 11:00pm, 1:00am, 3:00am, and 5:00am. They always skip the 11:00pm bed check, they do a bed check at 1:00am, then they start getting people up at 4:30am, so technically there is only one bed check, at 1am. V12 said there are times when perineal care is not done when changing incontinent residents due to time constraints, incontinence briefs are changed but the perineal area is not cleansed. This is happening a lot, mostly to confused residents who can't tell anybody what is going on. In regard to R1, V12 stated, She for sure did not get turned every two hours. She (urinated) a lot, but we did try to keep her dry, although she may not have got her perineal area cleaned. 2. R7's Admission Record documented an admitted [DATE]. Documented diagnoses include: Parkinson's Disease and Diabetes Type 2. R7's Minimum Data Set, dated dated dated [DATE] documented that R7 has no deficits in cognition and requires partial or moderate assistance from staff for toileting and transfers. R7's Care Plan with a revision date of 12/15/24 documented a problem area, (R7) has self-care deficit as evidenced by: Needs extensive assistance with ADLs related to contracture, weakness, impaired mobility, with a corresponding documented interventions including: Encourage the resident to use call bell for assistance and Toilet-use-one person physical assist required. On 1/3/24 at 10:35am, V2 stated it is her expectation that call lights should be answered within 15 to 20 minutes. On 1/3/25 at 1:10pm, R7 was alert and oriented to person, place, time, and purpose. R7 stated she has been complaining about call lights and staffing for the past few months, but it never improves. R7 stated she often waits an hour on her call light to get toileting assistance, and when CNA's finally respond, they tell her, They can't help it because they are short staffed. Sometimes they say what do you expect, there's nobody assigned to this hall, or there are only 2 CNAs in the whole building. R7 stated trying to get help is worse at bedtime, from about 7:00pm to 9:00pm. A Call Light Guidance Policy dated 8/20/22 stated, Resident call lights shall be responded to within a reasonable amount of time. An Incontinence Care Policy dated 5/16/22 documented, 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. 8. Wash all soiled skin areas and dry very well, especially between skin folds. 11. Change linen as needed. An undated Repositioning Procedure documented, Interventions. 3. Residents who are in bed should be on an at least every two hour repositioning schedule.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to implement interventions to prevent the development of pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 7. This failure resulted in R1 developing facility acquired moisture associated skin damage to the buttocks, a stage 2 pressure ulcer to the Left Ischium, a stage 3 pressure ulcer to the Right Ischium, and a stage 3 pressure ulcer to the Sacrum. Findings include: R1's Admission Record documented an initial admitted [DATE] and a readmitted [DATE]. Diagnoses listed include Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side, Type 2 Diabetes, Chronic Kidney Disease Stage 4 (Severe), Morbid Obesity, Epilepsy, and Aphasia. R1's 12/11/24 Braden Scale for Predicting Pressure Ulcer Risk documented a score of 11, indicating R1 is at high risk for the development of pressure ulcers. R1's Minimum Data Set, dated dated dated [DATE] documented that R1 is severely cognitively impaired to the extent that a Brief Mental Status Score could not be performed, was always incontinent of bowel and bladder, required substantial/maximal staff assistance for bed mobility, and was totally dependent on staff for transfers. The same MDS documents in Section M, Skin Conditions, that R1 is at risk for pressure ulcers/injuries and that R1 did not have any pressure ulcers/injuries. R1's Care Plan dated 12/8/24 documented a Focus area of, Pressure Ulcers, sites: Left Ischium, Right Ischium, Coccyx, with corresponding interventions, Repositioning every 2 hours and PRN (as needed). The same Care Plan also documents a Focus area of Potential for impaired skin integrity related to: Cognitive deficits, Decreased sensation, PVD (Peripheral Vascular Disease), DM (Diabetes Mellitus), hemiplegia right side, Impaired mobility, Incontinence. Documented interventions include Monitor Incontinence and provide pericare. R1's Wound Assessment and Plan Notes, authored by V6, Wound Care Nurse Practitioner, documented the following: 12/1/24: Wound location: Bilateral Buttocks, MASD (Moisture Associated Skin Damage) Wound onset date, 11/28/24. Irritant Contact Dermatitis due to dual incontinence. Coccyx, pressure injury, stage 3. Wound onset date, 11/28/24. 12/10/24:Wound location: Sacrum, pressure injury, stage 3. Declined. Wound onset date 11/28/24. Location changed (from Coccyx) to more accurately reflect current wound. Wound location: Bilateral Buttocks: Healed. Wound location: Left Ischium, pressure injury, stage 2. Onset date 12/10/24. Wound location: Right Ischium, pressure injury, stage 3. Onset date 12/10/24. R1's Nurses Notes dated 12/11/24 at 10:30pm stated, Resident not responding during care, lethargic. Resident had blood in urine and fever of 101.2. Sending resident to ER (emergency room) for evaluation and treatment. Power of Attorney and MD (Medical Doctor) aware. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's (local hospital) ED (Emergency Department) Note, Physician, dated 12/11/24 documented, It was brought to my attention that the family wanted the patient to stay locally. However, after reviewing the patients chart, the patient is noted to have elevated [NAME] (Blood Cell) Count of 19.3 and continues, And white (blood) cells in the urine which may indicate sepsis with abnormality in other organs. I ordered Ceftriaxone and the family was informed that the patient willing to be transferred for a higher level of care (at a regional hospital). Assessment: Dehydration, severe. Hypernatremia. UTI (Urinary Tract infection). A (Regional Hospital) Admitting Physician History and Physical Examination dated 12/12/24 documented, [AGE] year old female with a past history significant for Diabetes Type 2, Bilateral Carotid Stenosis, Hypertension, Seizure Disorder, PVD (Peripheral Vascular Disease) presented to (Regional Hospital) on 12/12/24 with Altered Mental Status. Assessment/Plan: Altered Mental Status,Hypernatremia, UTI, Sepsis present outside facility with respiratory rate of 25, Altered Mental Status, elevated [NAME] (Blood Cell) Count of 19.3, Sacral Decubitus Ulcer present on admission, AKI (Acute Kidney Injury) on CKD (Chronic Kidney Disease). On 12/26/24 at 9:20am, V4, R1's Power of Attorney, stated on 12/11/24, V2, Director of Nurses, calledV4 to state R1 had recently developed pressure areas, had experienced a deterioration in status, and the facility was sending R1 to hospital for treatment, where R1 was found to have a UTI. V4 stated she was told by V2 that R1's pressure wounds were [NAME] Ulcers, and V2 stated these were as a result of R1 being near the end of her life. V4 stated she does not believe this is accurate as R1 has since improved and has not been under hospice care. V4 stated V4 believed R1 developed pressure wounds due to not being repositioned and changed often enough, based on V4's history of working many years as a CNA (Certified Nursing Assistant). V4 stated as an example, V4 informed staff she wanted R1 get up to the wheelchair for meals, but when V4 visited, R1 often ate meals in bed. V4 stated staff told V4 that R1, Was a fall risk, had to be transferred with a mechanical lift, and they did not have enough staff to be able to supervise her while up. V4 stated she felt the facility was leaving R1 in bed all day for staff convenience. V4 stated after R1 was discharged from the hospital on 12/18/24, V4 had R1 sent to a different facility, where R1's wounds and overall condition have improved. On 12/27/24 at 9:35am, V9, CNA, stated she primarily works the 6am to 6pm shift. V9 stated incontinent residents on the 6:00pm to 6:00am shift are not being changed and repositioned often enough. V9 stated most mornings when V9 arrives, including the morning of 12/27/24, incontinent, confused residents are urine soaked, with dried brown rings on bed linens, and dried feces. V9 stated although there are supposed to be at least 3 CNAs and one nurse on the 6:00pm shift, at times there are 2 CNAs and one nurse, and such was the case the previous night. V9 stated when she has verbalized concern about care and staffing to Administration, she was told to call the corporate hotline to complain. On 12/27/24 at 10:15am, V8, CNA, stated she primarily works the 6am to 6pm shift. V8 stated the facility definitely does not have enough CNAs on the 6pm to 6am shift. V8 stated when she begins her shift at 6:00am, confused incontinent residents are frequently urine soaked, with brown rings on linens, and dried feces. V8 stated R1 was always incontinent of both bowel and bladder and was unable to reposition herself. When asked about R1 developing pressure wounds, V8 stated, She probably got them from not being turned and changed enough. V8 stated in regard to R1, They just tried to turn her as best they could when they remembered and tried to keep her clean and dry. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/2/25 at 11:40am, V12, CNA, stated she generally works the 6am shift but has also worked the 6pm shift as well. V12 stated both shifts are often short of CNAs. V12 stated when she started her shift that morning (1/2/25), several incontinent residents were soaked with urine and had odor and brown rings on linens due to the 6:00pm shift not changing them. V12 stated, There are definitely issues with people not getting turned and changed every 2 hours. V12 stated on the 6:00pm shift, They don't do bed checks like they are supposed to. Everybody is in bed by 8:00pm or 9:00pm, then they are to do bed checks at 11:00pm, 1:00am, 3:00am, and 5:00am. They always skip the 11:00pm bed check, they do a bed check at 1:00am, then they start getting people up at 4:30am, so technically there is only one bed check, at 1am. V12 said there are times when perineal care is not done when changing incontinent residents due to time constraints, incontinence briefs are changed but the perineal area is not cleansed. This is happening a lot, mostly to confused residents who can't tell anybody what is going on. In regard to R1, V12 stated, She for sure did not get turned every two hours. She (urinated) a lot, but we did try to keep her dry, although she may not have got her perineal area cleaned. V12 stated R1's family wanted her to get up to the wheelchair for meals, and when she (V12) worked with R1, she got her up. V12 stated complaints to Administration about staffing and care, Go nowhere. Nothing ever changes. On 1/2/25 at 2:25pm, V2, Director of Nurses, stated as far as she is aware, all dependent incontinent residents are being changed, receive perineal care, and are repositioned every two hours, including on the 6:00pm shift, and she has not heard otherwise. V2 stated R1's family would not have been told R1 couldn't be gotten up due to being a fall risk or not having enough staff to supervise her as those statements would not be accurate. V2 stated R1 developed MASD (Moisture Associated Skin Damage) to both buttocks and a stage 3 pressure wound to the Coccyx on 11/28/24 and was therefore referred to V6. V2 stated R1 went on to develop a stage 3 pressure area to the Right Ischial Tuberosity and a stage 2 pressure area to the Left Ischial Tuberosity, both acquired on 12/10/24. V2 stated she assumed all of these pressure areas were [NAME] Ulcers, associated with tissue breakdown at the end of life. V2 stated R1's condition continued to deteriorate and she was sent to the hospital on 12/11/24 due to nausea and vomiting and change in mental status. V2 stated a Urinalysis obtained prior to the hospital admission showed evidence of UTI. V2 stated at some point in December 2024, V4 had told V1, Administrator, that R1 would not be returning to the facility after hospitalization . On 1/3/24 at 10:15am, V1, Administrator, stated V4 came to the facility in December 2024, date unknown, to state that V4 did not believe that R1's wounds could have occurred that quickly and to that extent unless R1 was not being turned and changed frequently. V1 stated V4 said R1 would therefore not be returning to the facility. V1 stated as far as she knew, R1 was being changed and turned. V1 stated she told V4 that her understanding was that R1's areas were [NAME] Ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/3/24 at 11:05am, V6, Wound Care Nurse Practitioner, stated she evaluated R1 on 12/1/24 for facility acquired MASD to both buttocks, and a facility acquired stage 3 pressure wound to the Coccyx, both acquired 11/28/24. V6 stated she evaluated R1 again on 12/10/24, and found the MASD to the buttocks had resolved but R1 had a facility acquired stage 2 pressure area to the Left Ischium and a facility acquired stage 3 pressure area to the Right Ischium, both acquired 12/10/24. V6 stated on 12/10/24 the Coccyx wound had deteriorated to involve the entire Sacrum at a stage 3. V6 stated within December 2024, following R1's hospitalization , she resumed treating R1, at a different facility, and last evaluated R1 on 12/31/24. V6 stated all the pressure areas are now healing and R1's overall condition has improved. V6 stated she does not endorse the use of the term [NAME] Ulcers, and would not say R1 is currently at the end of life. V6 stated overall at the time the pressure areas developed, R1's overall health was in decline. V6 stated residents should be repositioned frequently to improve blood flow, but not necessarily every two hours, the time to reposition residents varies with each individual. V6 stated not being changed frequently and the perineum not being cleansed of urine and feces would be very damaging to the skin, probably more so than not being frequently repositioned. An Incontinence Care Policy dated 5/16/22 documented, 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. 8. Wash all soiled skin areas and dry very well, especially between skin folds. 11. Change linen as needed. The facility policy titled Skin Integrity Protocol (undated) documents Preventative Measures: 1. Turning, positioning and pressure redistribution {off-loading) will be utilized for all residents who have been identified of being at risk for developing pressure ulcers . 3. Minimizing exposure to moisture.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32619 Based on interview and record review, the facility failed to provide sufficient direct care staff for meeting resident needs in a timely fashion. This has the ability to effect all 50 residents living at the facility. Findings include: 1. R1's Admission Record documented an initial admitted [DATE] and a readmitted [DATE], and listed diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Right Dominant Side, Type 2 Diabetes, Chronic Kidney Disease Stage 4 (Severe), Morbid Obesity, Epilepsy, and Aphasia. R1's 12/11/24 Braden Scale for Predicting Pressure Ulcer Risk documented a score of 11, indicating R1 is at high risk for the development of pressure ulcers. R1's Minimum Data Set, dated dated dated [DATE] documented that R1 is severly cognitively impaired to the extent that a Brief Mental Status Score could not be performed, required substantial/maximal staff assistance for bed mobility, totally dependent on staff for transfers, and is always incontinent of bladder and bowel. Section H, Bladder and Bowel, documents that R1 is always incontinent R1's Care Plan dated 12/8/24 documented a problem area, Pressure Ulcers, sites: Left Ischium, Right Ischium, Coccyx, with corresponding interventions, Repositioning every 2 hours and PRN (as needed). On 12/26/24 at 9:20am, V4, R1's Power of Attorney, stated that she believed R1 developed pressure wounds due to not being repositioned and changed often enough, based on V4's history of working many years as a CNA (Certified Nursing Assistant). V4 stated as an example, V4 informed staff she wanted R1 get up to the wheelchair for meals, but when V4 visited, R1 often ate meals in bed. V4 stated staff told V4 that R1, Was a fall risk, had to be transferred with a mechanical lift, and they did not have enough staff to be able to supervise her while up. On 12/27/24 at 9:35am, V9, CNA, stated she primarily works the 6am to 6pm shift. V9 stated incontinent residents on the 6:00pm to 6:00am shift are not being changed and repositioned often enough. V9 stated most mornings when V9 arrives, including the morning of 12/27/24, incontinent, confused residents are urine soaked, with dried brown rings on bed linens, and dried feces. V9 stated although there are supposed to be at least 3 CNAs and one nurse on the 6:00pm shift, at times there are 2 CNAs and one nurse, and such was the case the previous night. V9 stated when she has verbalized concern about care and staffing to Administration, she was told to call the corporate hotline to complain. On 12/27/24 at 10:15am, V8, CNA, stated she primarily works the 6am to 6pm shift. V8 stated the facility definitely does not have enough CNAs on the 6pm to 6am shift. V8 stated when she begins her shift at 6:00am, confused incontinent residents are frequently urine soaked, with brown rings on linens, and dried feces. V8 stated in regard to R1, They just tried to turn her as best they could when they remembered and tried to keep her clean and dry. (continued on next page)

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	01/07/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/2/25 at 11:40am, V12, CNA, stated she generally works the 6am shift but has also worked the 6pm shift as well. V12 stated both shifts are often short of CNAs. V12 stated when she starts at 6:00am, incontinent residents are frequently soaked with urine and have odor and brown rings on linens due to the 6:00pm shift not changing them. V12 stated, There are definitely issues with people not getting turned and changed every 2 hours. V12 stated on the 6:00pm shift, They don't do bed checks like they are supposed to. Everybody is in bed by 8:00pm or 9:00pm, then they are to do bed checks at 11:00pm, 1:00am, 3:00am, and 5:00am. They always skip the 11:00pm bed check, they do a bed check at 1:00am, then they start getting people up at 4:30am, so technically there is only one bed check, at 1:00am. V12 stated there are times when perineal care is not done when changing incontinent residents due to time constraints, incontinence briefs are changed but the perineal area is not cleansed due to insufficient time to provide care. V12 stated, This is happening a lot, mostly to confused residents who can't tell anybody what is going on. In regard to R1, V12 stated, She for sure did not get turned every two hours. She (urinated) a lot, but we did try to keep her dry, although she may not have got her perineal area cleaned.V12 stated the 6:00pm shift CNA staff are to clean wheelchairs, which they are not doing. V12 stated complaints to Administration about staffing and care, Go nowhere. Nothing ever changes. On 1/3/25 at 9:10am, V2, Director of Nurses, confirmed she is the staff member responsible for scheduling nursing and CNA staff. V2 stated the facility requires a minimum of 5-6 CNAs and 2 nurses on 6:00am to 6:00pm shift, and 1 nurse and 3 CNAs on the 6:00pm to 6:00am shift, and that they are meeting this requirement, Most of the time. V2 acknowledged difficulty attracting and retaining CNA staff and stated call ins are a problem. On 1/3/25 at 12:50pm, V1, Administrator, stated complaints about call lights have come up in Resident Council for the past few months. V1 stated they are always hiring CNA staff, but the new hires frequently call in or no show. Resident Council Meeting Minutes documented the following: 11/6/24: Wheelchairs not being washed, call lights taking a long time to be answered. 12/4/24: Wheelchairs not being washed, call lights taking a long time to be answered. A Grievance Summary dated 11/6/24 documented the following: (Filed by an anonymous resident): Call lights taking a long time at times to answer. Summary of findings: At times it does take a little longer for the call lights to be answered, depending on the time of day and staffing. A December 2024 Staff schedule documented that on Sunday 12/1/24 from 6:00am to 6:00pm, there were three CNAs and one nurse working, with an additional nurse working 8:00am to 4:00pm. On Saturday 12/14/24 from 6:00am to 6:00pm, there were three CNAs and one nurse working, with a second nurse working from 8:00am to 4:00pm. A Daily Assignment Sheet dated Friday 12/27/24 documented that from 1:00am to 6:00am, two CNAs and one nurse worked. 2. R7's Admission Record documented an admitted [DATE] and listed diagnoses including Parkinson's Disease and Diabetes Type 2. R7's Minimum Data Set, dated dated dated [DATE] documented that R7 has no deficits in cognition and requires partial or moderate assistance from staff for toileting and transfers. (continued on next page)

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	01/07/2025

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