DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE HEALTH REHAB CENTER	**ONE PERRYMAN STREET** **LEBANON, IL 62254**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint # 1643294/IL86261 - No deficiencies Complaint # 1643299/IL86266 - F225, F226	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		

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

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.

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F 225	Continued From page 1	F 225		

incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to report an allegation of abuse immediately to the Administrator and delayed the initial investigation of potential abuse for 1 of 3 residents (R3) reviewed for abuse investigations in the sample of 10.

Findings include:

On 6/22/16 at 3:21 PM, E1, Administrator, and E2, Director of Nursing (DON), were asked if they were aware of an allegation of rough handling by E7, Certified Nursing Aide (CNA), during care of R3, that E7 poked R3's pressure ulcer when turned and that this incident was reported to E15 and E16, Licensed Practical Nurses (LPNs). E1 stated he was not aware of the incident and will initiate an investigation immediately. E1 stated he will notify E7 that he is suspended pending result of investigation.

The Facility Report to the Illinois Department of Public Health dated 6/22/16 at 3:25 PM documents an allegation of rough handling by E7 and that E7 poked R3's pressure ulcer while turning him and this allegation was reported to E15 and E16.

On 6/22/16 at 3:23 PM, E15 stated R3's family reported to her around 10:00 PM on 6/21/16 that E7 was very rough with R3 during care and R3 was afraid of E7. E15 stated she texted E2 about

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F 225	Continued From page 2 it but did not think it was abuse so she did not inform E1 about it. On 6/22/16 at 3:32 PM, R3 stated he does not have a pressure ulcer on his buttocks and stated he does not have any problem with the way staff takes care of him. R3 refused to talk regarding the allegation against E7. On 6/22/16 at 3:45 PM, Z2, R3's daughter, stated R3 reported to her on 6/21/16 that E7 was rough with R3 during care and poked on his pressure ulcer when E7 turned him. Z2 stated R3 told her this happened on the day before Father's Day. Z2 stated R3 told her he was scared and terrified of E7 and did not want E7 to come to his room. Z2 stated she reported it to E15. Z2 denied reporting the incident to anybody else in the facility. E16, LPN, could not be reached for an interview. On 6/22/16 at 4:43 PM, E7 stated he was always assigned to the first third of C Hall and R3 resided at the end of C Hall. E7 stated he has gone to R3's room to deliver his meal trays or answer his call light but he has not provided pericare to R3 since R3 was admitted a few days ago.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		

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F 226	Continued From page 3 by: Based on interview and record review the facility failed to operationalize it's Abuse Policy by not reporting an allegation of abuse immediately to the Administrator and delayed the investigation of potential abuse for 1 of 3 residents (R3) reviewed for abuse investigations in the sample of 10. Findings include: The Facility Policy on Abuse Prevention, Intervention, Investigation, and Crime Reporting, dated 12/2012, documents, "It is the responsibility of employees to promptly report to the facility administrator, local ombudsman (or local enforcement agency), and to State Licensing and Certification immediately or as soon as practically possible within 24 hours of detection, any incident of suspected or alleged neglect or resident abuse from other residents, staff, family, or visitors; including injuries of unknown source and theft or misappropriation of resident property. Reports shall be thoroughly investigated in a timely manner." On 6/22/16 at 3:21 PM, E1, Administrator, and E2, Director of Nursing (DON), were asked if they were aware of an allegation of rough handling by E7, Certified Nursing Aide (CNA), during care of R3, that E7 poked R3's pressure ulcer when turned and that this incident was reported to E15 and E16, Licensed Practical Nurse's (LPNs). E1 stated he was not aware of the incident and will initiate an investigation immediately. E1 stated he will notify E7 that he is suspended pending result of investigation. On 6/22/16 at 3:23 PM, E15 stated R3's family reported to her around 10:00 PM on 6/21/16 that	F 226		

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F 226	Continued From page 4 E7 was very rough with R3 during care and R3 was afraid of E7. E15 stated she texted E2 about it but did not think it was abuse so she did not inform E1 about it. On 6/22/16 at 3:45 PM, Z2, R3's daughter, stated R3 reported to her on 6/21/16 that E7 was rough with R3 during care and poked on his pressure ulcer when E7 turned him. Z2 stated R3 told her this happened on the day before Father's Day. Z2 stated R3 told her he was scared and terrified of E7 and did not want E7 to come to his room. Z2 stated she reported it to E15. Z2 denied reporting the incident to anybody else in the facility. On 6/22/16 at 4:43 PM, E7 stated he was always assigned to the first third of C Hall and R3 resided at the end of C Hall. E7 stated he has gone to R3's room to deliver his meal trays or answer his call light but he has not provided pericare to R3 since R3 was admitted a few days ago. E7 stated he was notified by E1 that he is suspended from work until the investigation is over.	F 226		