| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056671 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/23/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **RICHLAND NURSING & REHAB** | **900 EAST SCOTT STREET , OLNEY, Illinois, 62450** |

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| S0000 | Initial Comments<br><br>Facility Reported Incident of 10/9/2025/2645895 | S0000 | | 11/05/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br><br>300.1210b)<br><br>300.3210t)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>Section 300.3210 General<br><br>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. | S9999 | | 11/05/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review the facility failed to prevent resident to resident abuse for 3 of 6 (R1, R3 and R4) residents reviewed for abuse in a sample of 6. This failure resulted in R3 being bit on the wrist by R4, leaving a bruise, and R4 being grabbed by the shirt and slapped on the face by R3. A reasonable person being bit and slapped would feel fearful, intimidated, and threatened.<br><br>Findings include:<br><br>1. Facility form titled Long-Term Care Facility-Serious Injury Incident and Communicable Disease Report dated 10/10/2025 documented R3 resides at this facility and has diagnoses of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety among others. This report documented R4 also resides at this facility and has diagnoses of cerebral infarction, aphasia following cerebral infarction, unspecified dementia, severe, with other behavioral disturbance; bipolar II disorder; Guillain-Barre syndrome; major depressive disorder among others.<br><br>This same form titled Long-Term Care Facility-Serious Injury Incident and Communicable Disease Report dated 10/10/2025 documented under Detailed Incident Summary-Final: It was reported to Admin (Administration) on 10/10/2025 that two residents living on the (dementia unit) had an altercation. Staff witnessed (R3) grab (R4) by the shirt and slap (R4) across the face. (R3) stated that (R4) was in (R3's) room and she (R3) was walking (R4) out. (R4) bit (R3) on the wrist and (R3) grabbed (R4) by the shirt and slapped (R4). Residents were immediately separated and placed on 15-minute checks for 24 hours with no further incidents.<br><br>On 10/20/2025 at 1:45pm, V7 (CNA) said she was working the dementia unit on 10/10/2025. V7 said around 3:00pm, she seen R4 and R3 starting to have issues, but they were down at the end of the hall, but she could see them well. V7 said R3 and R4 were grabbing towards each other and R3 slapped R4 on the face because R4 had bit R3 on the wrist. V7 said V5 (Licensed Practical Nurse) was also a witness.<br><br>On 10/20/2025 at 1:55pm, V5 said she witnessed R3 grab R4's shirt and then slapped R4 across the face. V5 said she asked R3 why she hit R4 and R3 replied "She was in my room, and I was walking her out and she bit me." V5 | S9999 | | |

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| S9999 | Continued from page 2<br>said R3's left wrist had a small, bruised area but was not open or bleeding. V5 said R4's face was not injured but R4 had a small bruise on the right upper arm that she felt may have been caused by R3 grabbing R4's shirt, but she wasn't sure. V5 said R3 and R4 were immediately separated with no further issues.<br><br>On 10/22/2025 at 8:43am, R4 was noted to be edentulous. On 10/22/2025 at 8:45am, when asked, V15 (CNA) verified R4 did not have teeth.<br><br>Facility policy titled Abuse Prevention Program (revision date 9/29/22) documented in part, Abuse is (defined as) the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish and willful means the individual must have acted deliberately. This facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment.<br><br>2. R1's Care Plan documented admission to the on 3/9/2024 and included diagnoses of dementia with other behavioral disturbances and anxiety disorder. R1's Care Plan documented on 3/9/2024, R1 has focused problem areas of wandering behaviors, at risk for injury related to impaired safety awareness, cognitive impairment due to dementia and at risk for falls due to history of falls, cognitive impairment and decreased strength and endurance.<br><br>R2's Care Plan documented admission to this facility on 9/23/2025 and included diagnoses of dementia without behavioral disturbance, Diabetes type 2, history of traumatic brain injury, bipolar and major depressive disorder without psychotic features. R2's Care Plan documented on 9/23/2025, R2 has focused problem areas of new to facility, needs to adjust to new environment, needs assistance with activities of daily living, and at risk for falls due to history of falls and cognitive impairment. On 10/9/2025, R2's Care Plan was updated to include a new focused problem area of behaviors of wandering and physical aggressiveness towards other residents.<br><br>On 10/20/2024 at 8:45am, V1 (Administrator) said R2 was recently admitted to this facility on 9/23/25 from a sister facility. V1 said R2 has dementia and has severe cognitive impairment with a BIMS (Brief Interview for Mental Status) score of 4. V1 said nothing in R2's transfer paperwork documented any previous aggressive behavior and specifically documented R2 was non-aggressive but needed a more secure unit due to | S9999 | | |

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| S9999 | Continued from page 3<br>high elopement risk. V1 said the sister facility was not secure enough for R2's needs. V1 said R2's family agreed to R2 transferring to this facility and R2 was admitted to the dementia unit. V1 said since being admitted, R2 has not shown any aggressive behavior and has not been involved with any incidents or peer-to-peer altercations until 10/9/2025 when R2 hit R1. V1 said after the incident, R2 was placed on 1:1 supervision and moved to a different secured unit in the facility. V1 said R2 is doing well on the new unit and has not had any issues or aggressive behaviors. V1 said the incident between R1 and R2 was witnessed by V10 (Wound Care Nurse), V3 and V4 (both Certified Nursing Assistants/CNAs).<br><br>On 10/20/2025 at 12:30pm, V3 said on 10/9/2025 around 2:00pm, she was in the hallway on the dementia unit. V3 said she could see R1 walking down the hallway and was by R2's bedroom doorway. V3 said R2 came out into the hallway and hit R1 on her right shoulder. V3 said R1 took a few steps then lost her balance, fell towards the wall and to the floor. V3 said she told V4 to go get the nurse while she stayed with R1 and R2 went and sat on his bed.<br><br>On 10/20/2025 at 1:00pm, V4 said she also witnessed the same event. V4 said she was a few feet away from R1 and R2 when she saw R2 hit R1 on the shoulder. V4 said R1 took a few steps away, lost her balance, and fell to the floor. V4 said R2 went and sat down on his bed, and she ran to get the nurse (V10). V4 said when she returned, she asked R2 why he hit R1 and R2 answered, "I thought she was going in my room. I was trying to keep her out of my room."<br><br>On 10/20/2025 at 12:15pm, V10 said when she arrived, R1 was sitting on the floor in the hallway. V10 said R1 was not bleeding but she felt R1's right leg looked injured. V10 said she called 911 got R1 sent to the hospital where it was determined R1 had a broken right hip. V10 said R2 was immediately placed on 1:1 supervision and the next day was moved to a new unit. V10 said she had not seen any aggressive behavior or issues with R2 since he was admitted to this facility.<br><br>Facility form titled Long-Term Care Facility-Serious Injury Incident and Communicable Disease Report dated 10/9/2025 documented under Detailed Incident Summary-Final: It was reported to Administrator by Wound Nurse of a resident-to-resident altercation. (R1) was walking by (R2's) room when (R2) stepped out and hit (R1) in the right side of her shoulder and face. (R1) fell on her left side. Residents were immediately separated, and (R1) was assessed by the nurse and | S9999 | | |

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| S9999 | Continued from page 4<br>transported to the hospital with a right hip fracture. (R2) was moved to the (name of behavioral unit) before (R1) returned to the facility. One on one supervision with (R2) was initiated immediately. Check ins with Social Services were also initiated. No further aggressive behaviors have been observed since the incident. Families, Police and MD were notified.<br><br>Hospital records for R1 dated 10/9/2025 documented R1 presented to the emergency room via EMS (emergency medical service) for right hip pain. SNF (Skilled Nursing Facility) reports patient was pushed down, landed on right hip with immediate pain with movement to RLE (right lower extremity) and unable to get up post fall. On arrival with RLE shortening and external rotation. These same hospital records documented on 10/10/2025, R1 underwent right hip fracture repair procedure where a right intramedullary rod was inserted to repair the fracture.<br><br>(B) | S9999 | | |