STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145135	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richland Nursing & Rehab	900 East Scott Street Olney, IL 62450

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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.Findings include: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.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.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.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 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.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.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.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.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.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 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)