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	02/24/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from resident to resident physical abuse for 3 (R2, R7 and R8) of 3 residents reviewed for abuse in the sample of 9. This failure resulted in R2 being woken up to R1 having R1's hands over R2's mouth and nose while pushing down and with R2 yelling out she was trying to kill me., R7 being kicked in the leg above the knee by R5 and R8 being hit in the back by R5 a few hours later. A reasonable person being held down and potentially suffocated, kicked and slapped would feel fearful, intimidated, and threatened while residing in their home.Findings Include: 1.R2's Face Sheet documented an admission date of 10/31/18 with diagnoses that included other schizoaffective disorders, dorsalgia, unspecified, anemia, unspecified, chronic obstructive pulmonary disease, unspecified, and personal history of traumatic brain injury. R2's Minimum Data Set (MDS) annual assessment dated [DATE], documented a Brief Interview for Mental Status Score (BIMS) of 09, indicating R2 is moderately cognitively impaired. R2's Care Plan documented a focus area of psychosocial well-being; resident is considered at risk for abuse/neglect (per assessment) due to diagnosis of mental illness and forgetfulness. Start date 1/2/24.R1's Face Sheet documents R1 was admitted on [DATE] with diagnosis to include: schizoaffective disorder, bipolar type, and anxiety disorder.R1's Care Plan documents a problem area: resident is at risk for adverse consequence related to receiving antipsychotic medication for treatment of schizoaffective disorder with a start date of 7/10/25. Approach created 7/10/25, asses if the resident's behavioral symptoms present a danger to the resident and or/others. Intervene as needed. R1's Care Plan has a problem area: R1 is considered at risk for abuse/neglect with a start date of 7/9/25. Goal with a target date of 1/2/26, will remain free from secondary abuse.The Facility's Initial and Final Report of Incident documented a resident-to-resident altercation involving R1 and R2 on 12/7/2025 with the final report documenting it was reported to Administration on 12/07/2025 that there was an altercation between two residents living on(behavioral) Unit. An investigation was immediately initiated. R2 alleged that while she was sleeping, R1 came into her room and tried to suffocate her. The investigation of alleged abuse concluded that the altercation did occur due to interviews of both residents even though it was unwitnessed. On 2/17/2026 at 12:20 PM, R2 stated she does remember the incident on 12/7/2025 involving another resident. R2 stated she had been sleeping in her bed when she had woken up with R1 having her hands over her mouth and nose while pushing down. R2 stated that, R1 was trying to kill me. R2 stated when she opened her eyes, R1 backed out of her room while she had been yelling at her to get out of her room. R2 stated, if my television had not been in the way, I would have hit R1, because I was so mad. On 2/19/2026 at 11:16 AM, V12 (Licensed Practical Nurse/LPN) stated she did work the morning after the altercation between R1 and R2. V12 stated, she had been given report by V5 that she had heard R2 yelling from down the hallway and when looking down the hallway, R1 had been coming up the hallway. V12 stated V5 reported R2 yelling that R1 had tried to kill (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER Richland Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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	her. V12 stated R2 did tell her that she had been sleeping when she woke up to having R1 hovering over her with her hands over her mouth and nose. V12 stated R2 did tell her she thought R1 had been trying to kill her. V12 stated while R1 had been sitting in the wheelchair at the nurses station she did state that she did put her hands over R2's mouth and nose because R2 was injecting her toenails with something and made a comment about her calendar that did not make a lot of sense. V12 stated, R1 did demonstrate how she put her hands over R2's mouth and nose while talking to her about it. On 2/19/1026 at 11:32 AM, V8 (Psychosocial Case Manager) stated he had been made aware of the altercation between R1 and R2 after it occurred. V8 stated R1 had been crying and stated to her that she had entered R2's room and placed her hands on R2's mouth and nose. V8 stated, R2 did tell her the same information that R1 did. V8 stated R2 notified her that she woke up with R1 standing over her with her hands on her mouth and nose and pushing down. V8 stated R2 was upset and told her that if her television had not been in the way, she would have hit R1. On 2/19/2026 at 1:30 PM, V13 (Registered Nurse/RN) stated she did work the morning after the altercation between R1 and R2. V13 stated she had received report from V5, who stated R1 went into R2's room with gloves on and placed her hands over R2's mouth and nose. V13 stated R2 did tell her the same information while assessing her and doing 15-minute checks. V13 stated R2 had been very upset. V13 stated R1 did not tell her specifically what happened but did tell her that she had planned it out because R2 had been keeping all the fentanyl and it was not fair to anyone else. On 2/19/2026 at 2:00 PM, V5 (Licensed Practical Nurse/LPN) stated she had been working the night of 12/7/2025 when an altercation did occur between R1 and R2. V5 stated she and V6 (Certified Nurse Assistant/CNA) had been sitting up at the nurses station around 2-2:30 AM when she heard R2 screaming down the hallway. V5 stated, when she looked down R2's hallway, she observed R1 standing outside of R2's door and R2 yelling at R1 to get out of her room and she was going to kick R1's a*s. V5 stated she went down the hallway with V6 to assess the interaction. V5 stated R2 notified her that R1 had been in her room and when she woke up, R1 had been standing over her with her hands over her mouth and nose pressing down. V5 stated R1 went to her room and when interviewed about what took place, R1 did not deny putting her hands over R2's mouth and nose while pushing down. V5 stated R1 did have white plastic gloves on her hands. On 2/19/2026 at 3:10 PM, V6 (Certified Nursing Assistant/CNA) stated he had worked the night that R1 and R2 had an altercation. V6 stated he and V5 (LPN) had been sitting up at the nurses station when they heard R2 yelling down the hallway for R1 to get out of her room. V6 stated he looked down the hallway and saw R1 coming up the hallway with medical gloves on and R2 hollering for assistance. V6 stated he and V5 went down the hallway to investigate. V6 stated R2 notified them that she had woken up to R1 having her hands over her mouth and nose and was trying to suffocate her. V6 stated R2 was very upset. V6 stated R1 did go back to her room at that time. V6 stated R1 never denied that she did place her hands over R1's mouth and nose. R2's Progress Note dated 12/7/2026 by V5 (LPN) documented at approximately 0225 (2:25 AM) this nurse heard yelling down the hallway. R2 and R1 were outside R2's room and R2 told R1 to get the f**k out of my room and stay out. V6 CNA went down the hall before me and R2 told him that R1 had placed her hands on her face, mouth and nose and was trying to cut off her breathing. Upon assessing the situation, R2 told this nurse that R1 had placed her hands on her face forcefully and was pushing down trying to kill her. R2 told V6 CNA that R1 thought she had taken fentanyl patches from her. This nurse told resident that we would keep R1 out of her room and to let us know if she needs anything to which resident stated, I will probably just kick her a*s instead. This nurse educated against physical altercation and resident understood. 2. R7's Face Sheet documented an admission date of 06/18/2024 with diagnoses that included cerebral infarction due to unspecified occlusion or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER Richland Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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	stenosis of unspecified cerebral artery, aphasia following cerebral infarction, unspecified dementia, severe, with other behavioral disturbance, bipolar II disorder, schizoaffective disorder, bipolar type, major depressive disorder, recurrent, mild, and anxiety disorder, unspecified. R7's Minimum Data Set (MDS) annual assessment dated [DATE], documented under section B0600, Speech Clarity: Select best description of speech pattern with 2. No speech - absence of spoken words and B0700: with 2. Sometimes understood - ability is limited to making concrete requests. This same document had no BIMS Score suggesting R2 is severely cognitively impaired. R7's Care Plan documented a focus area of resident has communication deficit -expressive aphasia; related to cerebral vascular accident. Start date 6/21/24. Approaches include for staff to anticipate needs. With start dates of 6/21/24. R7 also has a focus area of R7 at risk for pain with a start date of 6/25/24. Interventions to include assess effects of pain on the resident by (disturbances in sleep, activity, self-care, appetite, psychosocial, etc.) Created 6/25/24.R5's Face Sheet documents R5 was originally admitted to the facility 8/30/24 with diagnosis to include: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and a cognitive communication deficit.R5's Care Plan documents a focus area of: resident exhibiting behaviors as seen by, wandering, verbally aggressive, physically aggressive (hitting, grabbing staff and residents), resisting care. Start date 9/30/24The Facility's Initial Report of Incident date 2/17/2026 at 4:30 PM documented a resident-to-resident altercation involving R5 and R7. Detailed incident summary documents reported to this writer of a resident-to-resident alleged altercation. Witnessed by 1 staff member. R5 kicked R7. Residents separated.On 2/20/2026 at 11:12AM, V2 (Assistant Director of Nursing/ADON) stated she had been notified of the altercation between R5 and R7. On 2/20/2026 at 12:25 PM, V17 (CNA) stated she had been working on 2/17/2026 when R5 and R7 had an altercation. V17 stated she had looked down the hallway and saw R5 entering R7's room. V17 stated she went down to R7's room to remove R5 and that is when she saw R5 had R7 blocked in the room with her wheelchair in the corner. V17 stated before she could intervene, R5 kicked R7 above the knee with her foot. R7's Progress Noted dated 2/17/2026 by V19 (Registered Nurse/RN) documents resident was kicked by another resident with no injury noted no c/o (complaints of) or s/s (signs/symptoms) of pain or discomfort and reported to V16 (Physician) and V3 (Regional Director), management aware. R7's Progress Note dated 02/17/2026 by V2 (Assistant Director of Nursing/ADON) documented skin assessment was completed by floor nurse after incident. No skin issues noted. POA (Power of Attorney) and V16 (Physician) notified, V1 (Administrator) also updated. Will continue to monitor. R5's Progress Note dated 2/17/26 at 4:55PM documents R5 kicked another resident and was easily directed. 15 minute checks started.3. R8's Face Sheet documented an admission date of 2/14/22 with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance, alzheimer's disease with late onset, other seizures, generalized anxiety disorder, major depressive disorder, recurrent, moderate, paroxysmal atrial fibrillation, delusional disorders, and chronic diastolic (congestive) heart failure. R8's Minimum Data Set (MDS) annual assessment dated [DATE] documented a BIMS of 99, indicating R8 is severely cognitively impaired. R8's Care Plan documented a focus area of at risk of abuse/neglect related to dementia with a start date of 5/27/22. The Facility's Initial Report of Incident documented a resident-to-resident altercation involving R5 and R8 on 2/17/2026 at 7:00 PM. Detail summary documented, reported to this writer of an alleged resident to resident altercation. It was reported that R5 hit R8 in the back. Resident's were separated and assessments were completed. No injuries were noted. R8 was placed on 15-minute checks and R8 is to be kept in the direct line of sight of staff until further notice.On 2/20/2026 at 11:10 AM, V1 (Administrator) stated she had been made aware via phone by V19 (RN) that there was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER Richland Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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	witnessed altercation between R5 and R8. On 2/20/2026 at 12:27 PM, V17 (CNA) stated she had been working on 2/17/2026 and witnessed the resident-to-resident altercation between R5 and R8. V17 stated it was towards the end of her shift when she had been sitting up at the nurses station with R8 sitting in her wheelchair. V17 stated, she witnessed R5 self-ambulate her wheelchair up behind R8 and R5 slapped R8 on her back. V17 stated, she did separate R5 and R8 and notified V19 and V1 (Administrator). R8's Progress Note dated 2/18/2026 by V2 (ADON) documented R8's POA (power of attorney) had been called and updated in regard to altercation around 645pm yesterday evening and updated of incident. All questions answered. V11 (Psych NP) also updated and made aware. Floor nurse completed skin assessment and no new issues. Will continue to monitor. R5's Progress Notes dated 2/18/26 at 10:33AM documents in part, at approximately 6:30PM on 2/17/26 this resident hit a different resident in the back.The facility policy titled Abuse Prevention Program (revised November 26, 2025) documented under Definitions: Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This same document under step 6. Protection of Residents documented the facility will take steps to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress and will immediately take appropriate steps to remediate the non-compliance and protect residents from additional abuse.