STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145454	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carlinville Rehab & Hcc	751 North Oak Street Carlinville, IL 62626

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 - Minimal harm or potential for 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 prevent resident to resident abuse in 2 of 4 residents (R5, R6) reviewed for abuse in the sample of 17. Findings Include:1.On 4/15/26 at 1:50 PM, R5 was unable to recall any details of the alleged incident with R16. R5's Face Sheet, undated, documents R5 has the following diagnoses: Hemiplegia/Hemiparesis following CVA (Cerebral Vascular Accident), Bipolar Disorder, Weakness, and Cognitive Communication Deficit.R5's MDS (Minimum Data Set), dated 3/23/26, documents R5 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R5 is cognitively intact.R5's Progress Note, dated 1/19/26 at 4:51 PM, documents the following: SSD (Social Service Director) visited resident today. Resident stated that she has no trauma from the resident to resident. Resident stated that she just ignores the other resident now.On 4/15/26 at 2:35 PM, R16 stated she did hit and pull R5's hair, she shouldn't have done it, and she is sorry. R16 stated her and R5 get along and she hasn't had any further incidents with R5 or any of the other residents. R16's Face Sheet, undated, documents R16 has the following diagnoses: Cerebral Infarction, PTSD (Post Traumatic Stress Disorder), Depression, and Bipolar Disorder.R16's MDS, dated [DATE], documents R16 has a BIMS score of 15 and is cognitively intact.R16's Progress Note, dated 1/19/26 at 4:49 PM, documents the following: SSD visited resident today. Resident stated she has no trauma from the resident to resident. Resident stated that she knows she should not have touched the other resident.The Facility Abuse Investigation Final Report, dated 1/23/26, documents the following: Resident to Resident altercation on 1/16/26 involving R5 and R16. R5 reported to Administrator when she was coming into the building from smoking, R16 pulled her hair and hit her in the back of the head for moving too slowly. R16 reported she was attempting to get to her table and asked R5 to move. According to R16, R5 then called her a fat cow. R16 explained she asked R5 to move and again, she refused at which time she said she barely hit her on the head and pulled her hair. R16 felt that she did not harm R5, although admitting she should not have done what she did. R5 stated she told R16 she was going as fast as she could when R16 told her to get out of her way. R5 stated she was then told to move now and then R16 called her names regarding her weight. R5 explained she did retaliate by calling R16 names as well. R5 stated they bantered back and forth, with R16 eventually hitting the back of her head and pulling her hair twice. R5 explained she had not been injured but felt R16 should not have done this. After the completion of a thorough investigation, we did find evidence to substantiate R16 pulled R5's hair and hit her lightly on the head as R5 was not moving fast enough. Although this incident did occur, both residents stated they were not harmed and had a disagreement. The residents haven't had any further occurrences since the initial incident. Residents have had a discussion, resolving their issues. Care plans have been updated to include both residents' meeting with social services to discuss any further frustrations and effective communication with other residents. Both residents have also been educated to request staff assistance when attempting to navigate challenging interpersonal situations.2. On 4/16/26 at 10:10 AM, R6 stated there was an incident with her former roommate R17, when she (R6) was in bed and R17, who is confused was telling her she shouldn't be in that room, it (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 - Minimal harm or potential for actual harm Residents Affected - Few	was hers and she (R17) was going to take care of her. R6 started R17 then grabbed her TV (Television) remote, began swinging it around and hit R6 on the right hand and head, causing bruising and pain to her hand. R6 stated the facility wanted to get her hand x-rayed but she knew it wasn't broken so she decided not to have it done. R6 stated she hasn't had anything like that happen since. R6 stated she feels safe in the facility. R6's Face Sheet, undated, documents she has an admitting diagnosis of Acute Respiratory Failure with Hypoxia.R6's MDS, dated [DATE], documents R6 has a BIMS score of 15, indicating she is cognitively intact.R6's Progress Note, dated 2/13/26 at 5:05 PM, documents the following: Around 5:05 PM, this nurse heard yelling coming from resident's room. Resident roommate observed to be swinging bedside remote at resident. Resident states that she got hit 3 times on the hand, forearm, and head. Roommate taken out of resident's room immediately. Some redness noted to resident's left forearm no other new skin issues noted. Administrator in the facility made aware of resident-to-resident event. Around 5:10 PM the NP (Nurse Practitioner) called made aware of the resident-to-resident event. Around 5:20 PM, resident's son called and was made aware of the situation and spoke with resident herself. Resident states she is okay now that the other resident is out of her room.R17's Face Sheet, undated, documents R17 had an admitting diagnosis of Malignant Neoplasm.R17's MDS, dated [DATE], documents R17 had a BIMS score of 15, indicating she was cognitively intact.R17's Care Plan, dated 2/20/26, documents R17 can get physically aggressive towards other residents.R17's Progress Note, dated 2/13/26 at 5:08 PM, documents the following: Around 5:05 PM, heard yelling coming from resident's room. When walking into the room resident was observed to be sitting on the side of the bed holding her TV remote. Resident noted to be swinging her bed remote at roommate. When this nurse tried to approach resident to grab the bedside remote, resident then began to swing remote at writer. Resident's roommate states that the resident swung and hit her with the bedside roommate 3 times. This nurse called for help. Resident was assisted to reclining wheelchair and removed from the room immediately. Administrator here in the building and reported resident to resident event. Resident moved to room B-05B. At 5:10 PM. NP called and updated about resident-to-resident event. At 5:17 PM, resident's sister, was called. Voicemail left to call the facility back. Around 6:00 PM, resident's sister called back and was updated about resident observed behaviors. Per resident's sister this is totally abnormal behavior for resident. Resident has never been aggressive in the past nor tried to harm someone. Sister also informed of resident moving to another room. This nurse informed sister that I will inform hospice and will call her with an update/new orders. Around 6:15 PM, new orders received for urinalysis with culture & sensitivity and to start Sertraline 50mg (milligrams) daily. Around 7:00 PM, resident's sister updated about new orders.The Facility's Abuse Investigation Final Report, dated 2/13/26, documents the following: On 2/13/26 it was reported by V15, RN, that it was reported to him by R6 that R17 hit her with the TV remote. V15 separated the two residents immediately. R6 had a head-to-toe assessment and no concerns were identified. V17 was moved to a different room. R6 was unable to be interviewed further as she had been out of the facility since 2/15/26 for medical issues, unrelated to current incident. R17 did not remember the incident and only knows of it due to interview/report. V17 explained she is not typically aggressive, and she found out she also had a UTI (Urinary Tract Infection) and believed this to be the cause of her behavior. V15 stated that R6 reported to him that R17 hit her three times with the TV remote on her hand. V15 reported hearing R6 yell and when he entered the room, he found R17 waving the remote in the air. The IDT (Interdisciplinary Team) reviewed the investigation and based on statements, the facility determined R17 most likely hit R6 with the TV remote due to an altered state caused by a UTI.On 4/16/26 at 2:30 PM, V1, Administrator, stated she would expect the residents to be free from abuse.The Abuse, Prevention, and Prohibition Policy, dated 11/2025, documents the following: Each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone.