STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145488	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rushville Nursing & Rehab Ctr	135 South Morgan Street Rushville, IL 62681

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the Facility failed to notify medication changes to a Resident Representative for one of seven Residents (R1) reviewed for new medications in a sample of seven.Findings include:The Notification of Change Guideline Policy, dated 10/1/24, documents: it is the practice of the Facility that changes in Resident condition or treatment are immediately shared with the Resident or Resident Representative, according to their authority, and are reported to and consulted with the attending physician; resident/resident representative will be educated about treatment options and supported to make an informed decision; objective of the notification guidelines is to ensure Facility staff make appropriate and immediate notification to the Resident and/or Representative when there is a change in condition (significant treatment alteration including commencing a new form of treatment; document the notification and record any new orders in the Residents medical record; educate the Resident/Resident Representative about the plan to treat, risks and benefits of the proposed treatment.R1's Physician Order Sheet/POS, dated 2/1/26 through 2/28/26, documents R1's diagnoses including Vascular Dementia, with other behavioral disturbance, Major Depressive Disorder, Anxiety Disorder and Degenerative Disease of Nervous System. The POS also documents an order for an anti-depressant medication (Mirtazapine/Remeron) with a start date of 10/20/25 once a day at 5:00 pm and an insomnia medication (Rozerem/Ramelteon) with a start date of 12/8/25 at 8:00 pm.R1's current Care Plan documents: is at risk for adverse consequences related to receiving antidepressant medication (problem start date 09/02/2025); and displays long and short-term memory deficits as evidenced by Brief Interview for Mental Status/BIMS (score 7/15); and diagnosis of Vascular Dementia, moderate, with other behavioral disturbance (problem start date 09/02/2025).R1's Face Sheet documents V5 (R1's Power of Attorney/Sister) as R1's Emergency Contact and Power of Attorney.R1's Nursing Progress Notes, dated 10/20/25 and 12/8/25, do not document notification of medication changes to V5 (R1's Power of Attorney/Sister).R1's Informed Consent for Psychotropic Medications form for Remeron/ Mirtazapine, dated 10/20/25, does not document V5 (R1's Power of Attorney) signature.R1's Informed Consent for Psychotropic Medications form for Rozerem/Ramelteon, dated 12/8/25, does not document V5 (R1's Power of Attorney) signature.On 5/26/26 at 11:59 am, V5 (R1's Power of Attorney/Sister) stated, I am (R1's) power of attorney and I was not notified of any medication changes that they put my brother (R1) on, and they let him (R1) sign the consents, not me, for the phototropic medications. R1 is cognitively impaired, I am not sure how he was able to sign for consent and understand the medications.On 5/30/26 at 11:00 am, V2 (Director of Nursing) stated, It is our policy to notify a power of attorney and also have them sign required consents for medications changes especially when we have a cognitively impaired Resident.

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure staff respected R1's right to refuse care, failed to prevent staff from using physical force during care, and failed to protect R1 from abuse when staff held R1's arms and hands down and provided care against R1's expressed refusal while R1 repeatedly yelled No, Get off me, and Let go of me. These failures resulted in R1 being manually restrained during care, caused R1 fear, distress, and psychosocial harm, and created Immediate Jeopardy to resident health and safety.These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 10/28/25 when staff forced care on R1 despite R1's refusal and signs of distress. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on 5/28/26 at 9:25 am. While the immediacy was removed on 5/30/26, the Facility's noncompliance remained at a Severity Level Two due to the need for additional monitoring to evaluate the implementation and effectiveness of the facility's plan of correction.Findings include:The facility's Abuse Prevention policy, dated 2/2020, documented the facility affirms the right of residents to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. The policy documented abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy further documented a physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to a resident's body that the resident cannot remove easily and that restricts freedom of movement.The facility's Resident Rights policy, undated, documented residents must not be abused by anyone physically, verbally, mentally, financially, or sexually. The policy documented the facility must make reasonable arrangements to meet residents' needs and choices.R1's Face Sheet documented R1 had diagnoses including vascular dementia, anxiety, depression, and chronic pain.R1's Care Plan documented R1 had behaviors including refusal of care, yelling/screaming out, harm to others/combative behavior with care, and difficulty falling or staying asleep. The Care Plan directed staff, when R1 became combative during care to the point staff safety was threatened, to ensure R1 was safe, remove themselves from the situation, and re-attempt care later. The Care Plan also directed staff to allow R1 to make decisions regarding the scheduling of care, redirect or intervene when R1 had increased agitation, and anticipate R1's needs to decrease agitation. Staff violated the Care Plan when they continued providing care after R1 repeatedly refused and became increasingly agitated, physically held R1's arms instead of removing themselves from the situation, and failed to stop and re-approach later as directed by the individualized interventions.On 10/28/25 at 10:17 AM, a video recording taken in R1's room showed V3, V4, and V7/Certified Nursing Assistants entered R1's room and stated R1 needed to be cleaned up. R1 immediately responded, no, several times. V3 stood on R1's right side of the bed and attempted to wash R1's face. R1 continued to state, no, and grabbed toward V3. V4 stood on R1's left side of the bed and held R1's left hand and wrist. R1 yelled, get off me, and attempted to pull his arm away from V4. V3 told R1 to stop and continued washing R1's face while holding R1's right arm with her left hand.Approximately two minutes and twenty-seven seconds into the recording, V6/Licensed Practical Nurse entered the room. V4 pulled the sheet off R1's groin area, exposing R1's penis. R1 stated, hey, get off of me, while V7 began washing R1's perineal area. R1 continued yelling, Hey, get off of me, and attempted to pull his arm away from V3. V3 told R1, stop, and you need to get cleaned up. R1 responded, no, I don't. As V7 continued washing R1's perineal area, R1 repeatedly yelled, let go of me, and attempted to pull his arm away from V3. R1 pulled against V3's hold with enough force that V3's upper body moved.Approximately eight minutes and four seconds into the recording, V3 and V4 released R1's hands. R1 then calmed, stopped yelling for staff to get off him, and the situation de-escalated. Throughout the recording, R1 remained lying flat during care and showed physical and emotional distress, including noticeable changes in breathing, use of accessory muscles, and abdominal (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breathing.On 5/26/26 at 11:59 AM, V5/R1's family member stated R1 had a video monitoring system in R1's room that V5 reviewed frequently to check on R1. V5 stated the video showed R1 saw V3/CNA, V4/CNA, and V7/CNA approach the door to R1's room to provide care, and R1 immediately began yelling, No, loudly before care began. V5 stated none of the staff listened to R1 or asked if it was okay to wash him. V5 stated staff told R1 they were going to clean him up and then held R1's arms and hands while he was naked, lying in bed, pulling away, and yelling out.V5/R1's family member stated V3 and V4 held R1's arms and hands down to prevent him from moving while V7 cleaned his perineal area. V5 stated R1 yelled out the entire time care was provided and continued to refuse, but staff did not stop or listen to him. V5 stated anyone could tell R1 was in distress and wanted them to stop. V5 stated V5 made V2/Director of Nursing aware of the incident and was told by V2 staff held R1's arms to keep him from swinging at them because they had to give him a bath, even if it meant holding his arms. V5 stated V2 then asked, at what point is it neglect if we don't make him get cleaned up? V5 stated, R1 was forgetful, but he was able to make his needs known. Do they think it's okay to do that to people who are forgetful or confused and they have no rights because of that? That is wrong, and what I saw on the video is the definition of physical assault and battery.On 5/27/26 at 11:25 AM, V1/Administrator stated V1 and V2/DON were made aware of the incident by V5/R1's family member in October 2025 and reviewed the video when V5 sent it to them. V1 stated V5 alleged staff held R1 down against his will during care. V1 stated, we did not think it was abuse. V1 confirmed V3/CNA and V4/CNA held R1's hands and arms during care to keep staff from being hit while they bathed him. V1 stated R1 was a terrible, terrible resident to care for and it was a very difficult situation all around. V1 stated facility staff did the best they could to care for him.During the survey, V1/Administrator provided an in-service record titled Caring for Residents with Dementia, dated 10/29/25. The in-service documented, Forcing a person with dementia to bathe is illegal, constitutes assault, and is a form of elder abuse. The in-service further documented resistance to bathing is common among persons with dementia and is often related to confusion, fear, discomfort, sensory sensitivity, anxiety, memory loss, pain, and loss of control and dignity.On 5/27/26 at 12:20 PM, V3/CNA (who was present in the room on 10/28/25 providing care) stated (staff CNAs and nurses) had to hold R1's hand and arms during cares because he resists and refuses most of the time. (Staff) have to provide care to him regardless of his refusals because (staff) would get reprimanded for not providing cares.On 5/28/26 at 9:25 AM, V2/Director of Nursing confirmed she saw the video and confirmed V5/R1's family member reported an allegation of abuse in October 2025. V2 stated V1/Administrator and V2/DON did not think the CNAs holding R1's arms and hands to provide care was abuse. V2 stated she was unsure when refusal of care became neglect for a resident like R1 because R1 always refused care, but staff had a responsibility to provide care. V2 confirmed the staff in the room should have left the room and re-approached R1 after R1 said no and began yelling.On 5/28/26 at 9:57 AM, V6/LPN (who was present in the room on 10/28/25) stated, I was pregnant, and the CNAs were concerned about me when providing cares for R1. They would hold R1's hands and arms down so R1 would not hurt me. There were times when we would leave the room and re-approach R1 and it did work. We should have left the room that day and re-approached him. I was not aware that holding someone's hands and arms to provide care while they're refusing is abuse. I would not do this to any other residents who refused.On 5/28/26 at 11:48 AM, V7/CNA (who was present in the room on 10/28/25) stated she was only employed for a short time at the facility and stated, that's why I am not there anymore in reference to the care provided to R1.On 5/28/26 at 12:10 PM, V10/Nurse Practitioner stated it was not appropriate to hold a resident's arms down while providing care. V10 stated staff should fully explain what they are going to do before and during each step of care for a resident with dementia. V10 stated staff should have stopped when R1 began yelling out and then re-approached him.V1/Administrator and V2/Director of Nursing were notified of the Immediate Jeopardy on 5/28/26 at 9:25 AM.Abatement plan was received on 5/28/26 at 12:58 PM and was not approved. Revisions were requested.Abatement plan was resubmitted on 5/28/26 at 3:13 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	PM and was not approved. Revisions were requested.Abatement plan was resubmitted on 5/29/26 at 12:28 PM and was not approved. Revisions were requested.Abatement plan was resubmitted on 5/29/26 at 1:59 PM and was approved.On 5/30/26 the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:1. R1 no longer resides in the facility.2. On 5/28/26 an immediate facility-wide assessment was completed by V13 (Licensed Practical Nurse) to identify any residents at risk for abuse, inappropriate staff interventions, or improper handling of refusal of care. 3. On 5/27/26, all staff, including staff on leave or on vacation, were in-serviced by V13/LPN, V21, and V2 on the following: The facility Abuse & Retaliation Prevention Policy, to include assault by staff members if physically restraining a resident against their will while providing care. Resident rights and refusal of care include de-escalation of resident behaviors. All staff completed a post test on 5/28/26 to gauge their knowledge.4. On 5/28/26, pending an investigation, V22 (Corporate Director of Operations) suspended all staff (V1, V2 & V3) involved in the finding of Immediate Jeopardy. Completed 5/30/26

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely assessment, monitoring, physician notification, diagnostic evaluation, and intervention for significant changes in condition related to urinary catheter complications and signs and symptoms of urinary tract infection (UTI) for one (R1) of three residents reviewed for urinary catheters in the sample of three. The facility failed to recognize, investigate, escalate, and respond to repeated abnormal urinary findings and changes in condition despite R1's known history of recurrent UTIs, urosepsis, and rapid clinical decline requiring prior hospitalizations. The facility's repeated failure to identify and respond to ongoing signs and symptoms consistent with urinary tract infection and catheter complications resulted in delayed medical treatment and caused R1 to experience acute clinical deterioration, respiratory distress, sepsis secondary to urinary tract infection, supraventricular tachycardia requiring cardioversion, mechanical ventilation by bag-valve mask, positive airway pressure intervention, emergency hospitalization, and subsequent death on [DATE]. The facility's failure to recognize and respond to significant changes in condition related to infection created a situation likely to cause serious injury, harm, impairment, or death to residents. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when V16/Registered Nurse first documented abnormal urinary findings consistent with urinary tract infection and catheter complications and failed to initiate physician notification or intervention despite R1's history of recurrent urosepsis and hospitalizations. V22/Vice President of Operations was notified of the Immediate Jeopardy on [DATE] at 3:45 PM. The surveyor confirmed through interview and record review the Immediate Jeopardy was removed on [DATE]; however, noncompliance remained at a Severity Level Two due to the need for additional monitoring to ensure sustained implementation and effectiveness of corrective actions.Findings include: The facility's policy titled, Catheter Care, Urinary, dated 2005, documented the purpose of the procedure was to prevent infection of the resident's urinary tract. The policy further documented staff were to observe urine for unusual appearance including abnormal color and blood, observe the resident for signs and symptoms of urinary tract infection and urinary retention, and report findings to the supervisor immediately.The facility's policy titled, Urinary Tract Infections/Bacteriuria - Clinical Protocol, dated 6/2014, documented staff and practitioners were responsible for identifying individuals with signs and symptoms suggesting possible urinary tract infection. The policy further documented nurses were to observe, document, and report signs and symptoms including fever and hematuria in detail. Acute deterioration in previously stable chronic symptoms may indicate acute infection. Multiple concurrent findings, including fever with hematuria or catheter obstruction, were more likely to reflect a urinary source. The physician was to assist staff in identifying suspected sepsis related to urinary tract infection and determine whether hospitalization was warranted.The facility's policy titled, Change in a Resident's Condition or Status, dated 8/2008, documented the facility shall promptly notify the physician and resident representative of changes in the resident's condition or status. The policy defined a significant change as a decline or improvement that would not normally resolve itself without intervention, impacted more than one area of health status, and required interdisciplinary review or revision to the care plan. The policy further documented notification would occur as soon as possible and within 24 hours of the change.R1's Face Sheet documented R1 has diagnoses including history of UTIs, COPD (Chronic Obstructive Pulmonary Disease), urinary retention, depression, anxiety, and presence of indwelling urinary catheter. R1's Care Plan documented R1 requires an indwelling urinary catheter for urinary retention with interventions to assess drainage, change catheter as ordered, provide catheter care every shift and as needed, avoid obstruction in drainage, and report UTI symptoms (acute confusion, urgency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nausea/vomiting, chills, fever, foul odor, concentrated urine, and blood in urine).R1's progress notes were reviewed between [DATE] and [DATE], facility nursing staff documented ongoing abnormal urinary findings including blood-tinged urine, dark urine, thick sediment, mucus, orange urine, catheter obstruction findings, and decreased urinary output without documented physician or practitioner notification, nursing assessment, implementation of interventions, diagnostic testing, increased monitoring, or escalation of care. Multiple licensed nurses confirmed during interview they documented the abnormal urinary findings but did not notify the provider of a change in condition, nor were any interventions put in place until [DATE] when R1 was required emergency response.R1's labs were reviewed for this same time period and there were no lab results.V10/Nurse Practitioner progress notes between [DATE] and [DATE] were reviewed. There was no documentation addressing abnormal urinary findings despite nursing documentation during the same period identifying abnormal urinary symptoms. The progress notes documented diagnoses including recurrent urinary tract infections and urinary retention.On [DATE] at 11:59 AM, V5/R1's family member stated V5 maintained a video monitor in R1's room and repeatedly notified facility staff regarding concerns related to R1's urinary catheter and urine appearance including decreased output, blood, mucus, sediment, and lack of catheter irrigation on multiple occasions including [DATE], [DATE], [DATE], and [DATE]. V5 stated V5 was unaware if staff provided follow-up regarding interventions or further evaluation before R1's hospitalization on [DATE]. V5 stated, I am a registered nurse and was concerned he was septic because of all of these urinary symptoms and his history of urosepsis requiring hospitalizations.Interviews were conducted with V6/Licensed Practical Nurse, V12/Registered Nurse, V13/Licensed Practical Nurse, V14/Registered Nurse, V15/Registered Nurse, and V16/Registered Nurse regarding nursing progress notes documenting abnormal urinary findings for R1. All confirmed they documented abnormal urinary symptoms on multiple occasions and did not notify the provider regarding the change in condition.R1's nursing progress note, dated [DATE], documented bloody thick mucus discharge dried to R1's sheets and peri-area with blood-tinged urine noted in the urinary catheter tubing. There was no documentation of physician or practitioner notification, further assessment, diagnostic testing, intervention, or monitoring related to these findings.From [DATE] through [DATE], facility nursing staff entered 43 nursing progress notes documenting R1's abnormal urinary findings including dark urine, thick sediment, mucus, bloody or blood-tinged urine, and orange urine without documentation of physician notification, nursing assessment, diagnostic evaluation, implementation of interventions, or escalation of care.A nursing progress note entered by V6/LPN, dated [DATE], documented R1 was transferred to the emergency department by ambulance due to fever and respiratory distress.On [DATE] at 9:57 AM, V6/LPN stated the CNA working on [DATE] came and told her something was off with R1. V6 stated R1 was shaking, mumbling, and looked panicked when she entered R1's room on [DATE]. R1 had a fever and elevated respiratory rate. I didn't observe his catheter or urine that morning. V5 further stated V5 was not aware R1 had a significant history of UTIs with sepsis requiring hospitalizations. An attempt was made to call V10/Nurse Practitioner without success and EMS (Emergency Management Services) were called. R1 had dark urine, bloody urine, mucous, and malodorous often. It was always like that and V6 stated she did not report it to the physician. V6 stated she would report these symptoms for any other resident if symptoms persisted. R1's Ambulance Service Report dated [DATE] documented upon arrival emergency personnel found R1 in respiratory distress with cyanosis. Oxygen was initiated without improvement. R1 became less responsive and continued to decline. CPAP was initiated followed by bag-valve-mask ventilation due to worsening respiratory failure and unresponsiveness. Upon arrival to the emergency department, R1 was documented to be in supraventricular tachycardia with a heart rate of 236 while remaining unresponsive and requiring ventilatory support.R1's Emergency Department Provider Note dated [DATE] at 10:18 AM documented R1 arrived from the nursing facility in respiratory distress and altered mental status. The emergency department physician documented R1 had an indwelling Foley catheter with brownish (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sediments in the tube. Diagnoses included sepsis secondary to urinary tract infection, acute respiratory failure, and atrial fibrillation/supraventricular tachycardia refractory to cardioversion and medication intervention.R1's Hospital Genitourinary assessment dated [DATE] documented the Foley catheter tubing was obstructed in multiple areas with thick mucus and dried dark substances. Upon removal of the catheter, large amounts of brown, thick, mucous, foul-smelling drainage immediately expelled from the urethra saturating eight towels before slowing. Hospital documentation described the urine as brown, cloudy, concentrated, purulent, with mucus and sediment.R1's Hospital Emergency Documentation dated [DATE] documented after discussion regarding prognosis and sepsis diagnosis, R1's family elected to change R1's code status to comfort measures only.R1's Hospital Discharge Documentation dated [DATE] documented R1 expired on [DATE] at 12:28 PM.R1's death certificate documented the cause of death as respiratory failure secondary to sepsis.On [DATE] at 12:10 PM, V10/Nurse Practitioner stated R1 had a long history of recurrent urinary tract infections, urosepsis, and hospitalizations related to urosepsis and confirmed R1 declined rapidly when septic. V10 stated abnormal urinary findings including dark urine, sediment, blood, or mucus should have been reported to the provider for further follow-up and intervention. V10 confirmed there was no documented provider notification related to R1's urinary symptoms between [DATE] and [DATE]. V10 further confirmed if the provider had been notified regarding R1's urinary symptoms and change in condition, interventions could have been initiated sooner.On [DATE] at 2:20 PM, V9/Infection Preventionist stated symptoms of a possible urinary tract infection included foul-smelling urine, blood in the urine, sediment, mucus, and dark tea-colored urine.On [DATE] at 3:15 PM, V9/Infection Preventionist stated nursing staff should notify the physician regarding urinary abnormalities suggestive of infection and document physician notification in the medical record.On [DATE] the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediate Jeopardy:The abatement plan was submitted and accepted on [DATE] at 6:42 PM.R1 no longer resided in the facility.On [DATE], all licensed nurses, including those on leave or vacation status, received education regarding timely assessment, monitoring, physician notification, and intervention for urinary catheter complications and signs and symptoms of urinary tract infection. Education included assessment and escalation of changes in condition related to urinary abnormalities and infection. Post-testing was completed to evaluate staff understanding.On [DATE], all certified nursing assistants, including those on leave or vacation status, received education regarding signs and symptoms of urinary tract infection and the requirement to immediately report abnormalities to licensed nursing staff. Post-testing was completed to evaluate staff understanding.On [DATE], all residents with indwelling urinary catheters were assessed for signs and symptoms of urinary tract infection by facility nursing management and infection prevention staff.On [DATE], care plans for residents with urinary catheters were reviewed and updated to address monitoring and reporting of catheter-related complications and signs and symptoms of infection.All residents with indwelling catheter devices were assessed for a urinary tract infection.All Careplans for residents with catheters have been reviewed and updated as needed.The Medical Director was made aware.Quality Assurance monitoring was put into place.Completion Date: [DATE]