STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mascoutah Rehab and Nursing	201 South 10th Street Mascoutah, IL 62258

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. (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	**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 for 1 of 3 residents (R7) reviewed for abuse in the sample of 11.Findings Include: 1. R7's Undated Face Sheet, documents she was initially admitted to the facility on [DATE] with diagnoses including major depression disorder, anxiety disorder, chronic pain syndrome, paraplegia, anemia, heart failure, high blood pressure, osteoarthritis and neuropathy. R7's Quarterly Minimum Data Set (MDS), dated [DATE], documents BIMS 14 and no behaviors. R7's Nursing Progress Note, dated 7/29/2025 at 10:08 PM documented, res sustained skin tear to left forearm by another res holding her arm. Skin tear measures 0.4 centimeters (cm) x 0.3 cm. Area cleansed with NS (normal saline), steri strips applied. All parties notified. No documentation of a bruise on R7's left forearm. 2. R8's Undated Face Sheet, documents she was initially admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and mood disorder. R8's Quarterly MDS, dated [DATE], documents R8 is severely cognitively impaired, wanders daily, has disorganized thinking, inattention, altered level of consciousness, physical and verbal behaviors towards others occurred 4-6 days, other behaviors not directed towards others occurred 4-6 days and rejects care 1-3 days.R8's Nursing Progress Note, dated 7/29/2025 at 9:42 PM documented, res noted in another res room. Res confused and disoriented. When res asked him to leave out of room, he grabbed her left arm and held on to it causing a skin tear. Res requested assistance from staff to have him assisted out of room. Res taken to room & placed in bed. All parties have been notified.On 8/12/2025 at 1:35 PM, R7 sat up in her wheelchair in her room and stated a few weeks ago at around 9:30 PM R8 was in her room, when she told R8 to get out of her room he walked up to her grabbed both her forearms, and he squeezed them to death, and it hurt bad. R7 stated she had a large bruise to her left forearm and a skin tear. R7 stated the skin tear bled down her arm. Resident pulled left sleeve up and noted steri- strips on her left forearm, no bruising noted. R7 stated it scared the h*** out of her, but she didn't cry. R7 stated when she sees R8 down her hall now, she has staff redirect him because she doesn't want to get hurt again. R7 stated she knows R8 has Alzheimer's disease but that she wishes staff would redirect him more often because he really scared her that day.On 8/19/2025 at 12:30 R8 was observed sitting in the dining room at the facility. R8 didn't respond to any of the IDPH surveyor's question, R8 just starred straight ahead. On 8/19/2025 at 1:00 PM V20, LPN stated R8 is not alert and has Alzheimer's disease. Staff try to keep an eye on R8 because he often goes in other residents' rooms and lays in empty beds. R7 reported to her one night that while attempting to redirect R8 out of her room, R8 grabbed R7's left forearm which caused a skin tear. On 8/12/2025 at 2:15 PM V1 Administrator, V8 Regional Administrator and V2 Interim DON stated they were not aware of any resident-to-resident altercations on 7/29/2025. V1 stated she would have expected staff to report what occurred so she can start an investigation as soon as possible and put an intervention in place to prevent it from occurring again. V8 stated he didn't view the incident as a resident-to-resident altercation, he viewed it more as an incidental contact between R7 and R8. The Facility's Resident Right to Freedom of Abuse, Neglect and Exploitation policy, initiated 10/16/2023, documents the facility's residents have the right to be free from abuse, neglect, misappropriation of their property and exploitation as defined in this policy. The facility shall review altercations from resident to resident as a potential situation of abuse. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include physically aggressive behavior, such as grabbing and verbally aggressive behavior such as intimidating.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to investigate a resident-to-resident abuse for 1 (R7) of 3 residents reviewed for abuse in the sample of 11. Findings include: 1. R7's Undated Face Sheet, documents she was initially admitted to the facility on [DATE] with diagnoses including major depression disorder, anxiety disorder, chronic pain syndrome, paraplegia, anemia, heart failure, high blood pressure, osteoarthritis and neuropathy. R7's Quarterly Minimum Data Set (MDS), dated [DATE], documents BIMS 14 and no behaviors. R7's Nursing Progress Note, dated 7/29/2025 at 10:08 PM documented, res sustained skin tear to left forearm by another res holding her arm. Skin tear measures 0.4 centimeters (cm) x 0.3 cm. Area cleansed with NS (normal saline), steri strips applied. All parties notified. No documentation of a bruise on R7's left forearm. 2. R8's Undated Face Sheet, documents she was initially admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and mood disorder. R8's Quarterly MDS, dated [DATE], documents R8 is severely cognitively impaired, wanders daily, has disorganized thinking, inattention, altered level of consciousness, physical and verbal behaviors towards others occurred 4-6 days, other behaviors not directed towards others occurred 4-6 days and rejects care 1-3 days.R8's Nursing Progress Note, dated 7/29/2025 at 9:42 PM documented, res noted in another res room. Res confused and disoriented. When res asked him to leave out of room, he grabbed her left arm and held on to it causing a skin tear. Res requested assistance from staff to have him assisted out of room. Res taken to room & placed in bed. All parties have been notified.On 8/12/2025 at 1:35 PM, R7 sat up in her wheelchair in her room and stated a few weeks ago at around 9:30 PM R8 was in her room, when she told R8 to get out of her room he walked up to her grabbed both her forearms, and he squeezed them to death, and it hurt bad. R7 stated she had a large bruise to her left forearm and a skin tear. R7 stated the skin tear bled down her arm. Resident pulled left sleeve up and noted steri- strips on her left forearm, no bruising noted. R7 stated it scared the h*** out of her, but she didn't cry. R7 stated when she sees R8 down her hall now, she has staff redirect him because she doesn't want to get hurt again. R7 stated she knows R8 has Alzheimer's disease but that she wishes staff would redirect him more often because he really scared her that day.On 8/19/2025 at 12:30 R8 was observed sitting in the dining room at the facility. R8 didn't respond to any of the IDPH surveyor's question, R8 just starred straight ahead. On 8/19/2025 at 1:00 PM V20, LPN stated R8 is not alert and has Alzheimer's disease. Staff try to keep an eye on R8 because he often goes in other residents' rooms and lays in empty beds. R7 reported to her one night that while attempting to redirect R8 out of her room, R8 grabbed R7's left forearm which caused a skin tear. V20 stated she reported the incident to V8, Regional Administrator but that she didn't think it was a resident-to-resident altercation, V20 thought it was just a skin incident. V20 didn't ask R7 if she was scared of R8 and didn't note her left forearm was bruised. On 8/12/2025 at 2:15 PM V1 Administrator, V8 Regional Administrator and V2 Interim DON stated they were not aware of any resident-to-resident altercations on 7/29/2025. V1 stated she would have expected staff to report what occurred so she can start an investigation as soon as possible and put an intervention in place to prevent it from occurring again. V8 stated he didn't view the incident as a resident-to-resident altercation, he viewed it more as an incidental contact between R7 and R8. V1, V2 and V8 stated they started a resident to resident abuse investigation when it was brought to their attention on 8/12/2025. The Facility's Elder Justice Act and Reporting Suspected Crimes Against Residents Policy & Procedure, initiated 10/1/2023, documents it is the policy of the facility to empower and enable all owners, operators, employees, agents or contractors of the facility to make reports to the relevant authorities pursuant to the provision of the Elder Justice Act (EJA) and CMS regulations. Within five working days of the incident, the facility will provide in a follow-up investigation report. This report will contain information from the resident's record, summary of other documents obtained, sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified, who investigated the incident, and who is submitting the report.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to order a abdominal ultrasound, urinalysis/culture and sensitivity in a timely manner for 1 (R4) of 3 residents reviewed for timeliness of care in the sample of 3. This failure resulted in a nonverbal resident (R4) being transferred to the emergency room and diagnosed with a impacted stool in the intestine that was digitally removed from her rectum, enema, IV hydration and intramuscular shot for the urinary tract infection and put on oral antibiotics. Using the reasonable person approach, this failure caused pain, discomfort and invasive interventions during a hospital visit. Findings include: R4's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including cerebral palsy, constipation and GERD.R4's Care Plan, dated 3/31/2025 documents focus bowel and bladder incontinence. Interventions: record bowel movements, frequency, and consistency. Assess any signs of discomfort, burning or itching around anus, loss of appetite, etc. No documentation of R4's diagnosis of constipation was addressed/documented on her care plan. Another focus: R4 has a communication problem, she is nonverbal. Goal: R4 will feel heard and understood, as reflected in her body language and facial expressions. Interventions: encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense or respond to the feeling resident is trying to express. Monitor/document for physical/nonverbal indicators of discomfort or distress and follow-up as needed. R4's Annual Minimum Data Set, dated [DATE] documents she is severely cognitively impaired, no constipation present, both sides functional impairment in range of motion, wheelchair for mobility device, doesn't ambulate, dependent on staff for toileting, incontinent of bowel and bladder. R4's Physician's Order Sheet (POS), dated 12/2/2021 MiraLAX 17 grams by mouth every day for constipation. 12/2/2021 Senokot S 8.6 milligrams/50 mg two times a day for constipation and 1/27/2025 Bisacodyl 1 suppository rectally at bedtime every other night for constipation. R4's Medication Administration Record (MAR) dated 8/2025 staff documented physician prescribed medications to treat constipation were administered as ordered. R4's POS, dated 8/4/2025, documents a urinalysis and reflex culture (no reason for order) and an ultrasound abdomen and pelvis indication: mass in lower left quadrant.R4's Bowel and Bladder document, dated 8/3/2025 through 8/14/2025 staff documented R4 had a small bowel movement on 8/3/2025, large bowel movement on 8/9/2025 and 8/11/2025 and a small bowel movement on 8/12/2025. R4's Nursing Progress dated 8/4/2025 through 8/7/2025 no documentation as to why a urinalysis and reflex culture was ordered and no documentation if either test was collected/completed. R4's Nursing Progress Note, dated 8/7/2025 at 1:33 AM, documents attempted to get urine per sterile technique without success. No documentation if the ultrasound abdomen and pelvis was completed. R4's Physician's Progress Note, dated 8/8/2025 at 7:00 AM documents urinalysis and reflex culture sent. R4's Medical Record dated 8/8/2025 through 8/11/2025 showed no urinalysis and reflex culture, or ultrasound abdomen and pelvis results were not uploaded in R4's Medical Record. R4's Physician's Progress Note, dated 8/11/2025 at 7:00 AM, documents the patient is a poor historian due to cerebral palsy and aphasia. The patient history is taken from her family and nursing staff. The patient has been restless and agitation for the past week. There was possible grimacing and complaint of pain witness by her family. Anxiety versus GI/GU (genitourinary/gastrointestinal) symptoms, continuing to await US (ultrasound) and UA (urinalysis)/UC (urine culture.) R4's Medical Record was reviewed for the UA/UC and abdominal/pelvic ultrasound on 8/12/2025 at 12:00 PM. The results were not uploaded in R4's electronic medical record at that time. On 8/12/2025 at 12:10 PM V1, Administrator and V2, Interim Director of Nursing stated he noted a day or so ago that R4's UA/UC was not collected yet and the abdominal/pelvic ultrasound was not completed yet and he had been on the phone with the ultrasound company all morning trying to figure out why it wasn't done yet. V2 stated the ultrasound company informed him that the physician's order verbiage was not correct, and it needed the word limited to be added to it so the ultrasound would be covered by insurance. V2 stated he didn't know why the physician ordered a UA/UC other than to rule out a UTI and the ultrasound abdomen/pelvis was ordered because R4's physician felt a mass in her abdomen. V2 wasn't aware the laboratory and ultrasound tests were not completed until the surveyor requested the test results, that's when he started making calls to see why the tests were not completed. V1 stated when a physician orders a lab test and/or an ultrasound she expects the UA to be collected and sent off to the lab the next day and if it was attempted to be collected and unsuccessful, the nurse should report that to the oncoming nurse and that nurse should attempt to collect the specimen. If