STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145546	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Zion Health & Rehab Center	1225 Woodland Drive Mount Zion, IL 62549

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. Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident. This failure affects two residents (R1, R2) of four reviewed for abuse in the sample of four.Findings include:The facility Abuse Policy (1/9/2024) documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.R1's Medical Diagnosis list (4/9/2026) documents R1's diagnoses include: Generalized Anxiety Disorder, Major Depressive Disorder, and Parkinson's Disease (neurodegenerative disorder causing slow movement, muscle stiffness, and balance issues).R1's Resident Assessment (5/8/2025) documents R1 has moderately impaired cognition.The facility abuse investigation file (3/6/2026) documents R2 approached R1 in the facility hallway on 3/5/2026 and struck R1 in the arm twice. On 4/8/2026 at 1:35PM, V3 (Certified Nurse Aide) reported observing R2 strike R1 with a closed fist in R1's upper arm area on R1's right side and then hollered at R2 to not do that and then as V3 began walking towards R1 and R2, R2 hit R1 again with a closed fist in the lower right forearm area. V3 reported R2 was kind of aggressive towards staff when we went to provide care and would get overwhelmed with noise and would get agitated. V3 reported never seeing R2 hit someone like that before. V3 reported R2 had tried to hit some of the staff before. V3 reported providing care to R2 since R2's admission to the facility and reported R2 was not always having delirium and R2's agitation onset (on 3/5/2026) was sudden. V3 reported R1 just sat there and then R1 stated R1 was scared and cried a little bit but wasn't completely distraught. V3 reported once R2 left, and R1 had a snack, R1 was ok. V3 reported R2 stated R2 wanted to hit R1 and told the nurse that R2 would hit R1 or anyone else too and R2 was separated (from further potential resident contact) until the ambulance arrived to take R2 to the hospital for evaluation.

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