STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145760	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Rehab and Nursing	600 East Robinwood Drive Robinson, IL 62454

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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	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 provide increased staff supervision in order to protect a resident from resident-to-resident abuse for one (R2) of three residents reviewed for abuse in the sample of three. This failure resulted in R1 threatening, hitting and throwing water on R2, and with R2, upon staff directives, curtailing his normal activities to try to avoid R1.Findings include:R2's admission Record documented an admission Date of 12/14/25 and listed Diagnoses including Diabetes Type 2 and Depression. A Minimum Data Set, dated [DATE] documented that R2 had a BIMS (Brief Interview for Mental Status) score of a 12, indicating R2 had moderately impaired cognition.R2's Care Plan dated 5/24/26 documented a problem area, I prefer to help with small chores. I helped my mother and sister for several years. I like to help to give myself a purpose, with a corresponding intervention, I understand that I am only to assist my mom (who is a resident) by pushing her wheelchair and not other residents in this facility, and problem area, I currently have an alteration to my ability to care for self and need assistance due to (being) developmentally delayed.R2's Nurses Notes documented the following:5/24/26: Resident was slapped by (R1) this evening at 19:00 (7pm). Incident was witnessed by two staff members who both stated they observed (R2) was pushing (R1) backwards in their wheelchair and (R1) reached up and slapped this resident across the left side of his face. This nurse was called and upon responding observed this resident and (R1) who struck him in the hallway with a CNA (Certified Nursing Assistant) standing between them. (R1) was still agitated and shaking his fist at this resident. This resident continued to lean in and allow his face to get near other resident's striking distance, further agitating (R1). This nurse intervened and took (R2) to the dining room. (R2) was assessed and no injuries could be determined. (R2) denied any pain. (R2) stated he was pushing (R1) out of the middle of the hall so the CNA could get through with the sit-to-stand lift and noticed (R1) had a clothing protector in his lap, but when he went to take it, (R1) reached up and slapped him. Advised this resident to not interact with (R1) East Hall nurse was notified that (R1) had become aggressive, and that (R1) was taken to their room at 19:15 (7:15pm). Neuro(logical) checks were initiated on (R2) related to head trauma and were consistent with resident's baseline.5/25/26: This nurse has reminded and instructed (R2) to stay away from (R1). Resident continues to go in proximity of (R1). After dinner this resident was close enough to (R1) and was able to throw water on him. Again, this nurse instructed (R2) to stay away from (R1), who is in wheelchair and very slow when wheeling self. Notified (R2's) family who also reminded resident to stay out of proximity of (R1). (V2, Director of Nursing and V1, Administrator) (were)notified of incident.9:15. Neuro checks were initiated on this resident related to head trauma and were consistent with resident's baseline.R1's admission Record documented an admission Date of 4/3/26, a discharge date of 6/5/26, and listed Diagnoses including Chronic Kidney Disease, Osteoporosis, and Cognitive Communication Deficit. A Minimum Data Set, dated [DATE] documented that R1 had a BIMS score of a 14 indicating R1 was cognitively intact.R1's Care Plan dated 5/24/26 documented a problem area, I have an alteration to my behavior- aggressive behaviors: 5/24/26 Incident involving another resident, with a corresponding intervention, 15-minute checks. R1's Wandering/Elopement Risk assessment (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] documented that R1 was at high risk for wandering and elopement.R1's Nurses Notes documented the following:5/24/26: (V5, Licensed Practical Nurse/LPN), the second nurse in the building informed this nurse that this resident that was under this nurse's care (R1) had, taken a swing at another resident (R2). (R2) was under (V5's) care. This nurse immediately took this resident (R1) back to his room and called V1, Administrator and Abuse Coordinator for this facility. Within minutes (V1) called this nurse back and clarified that this resident had actually made contact and struck (R2) in the jaw. This nurse assisted in preparing (R1) for bed and explained to (R1) that hitting was unacceptable behavior. (R1) is currently resting in bed, eyes closed and call light within easy reach.5/25/26: It was reported to this nurse from dayshift nurse, that (R1) was agitated with (R2) at supper and threw a cup of water on (R2). Also stated that (R1) ran over (R2's) foot with wheelchair. That nurse contacted (V2, Director of Nurses) and (V8, Assistant Director of Nurses) and alerted them of occurrence. Resident placed on 15-minute checks to monitor whereabouts and behaviors. Resident removed from other resident and no behaviors are present at this time. Sitting in wheelchair drinking hot chocolate, at this time wheeling down hallway. Staff frequently visual monitoring. No behaviors present at this time.There was no documentation in R1 or R2's record to indicate an abuse investigation was started following R1 throwing water on R2. There was no documentation in either record to indicate an increased level of monitoring was implemented after this incident.An IDPH (Illinois Department of Public Health) Long Term Care Serious Injury Incident and Communicable Disease Report dated 5/24/26 documented, Incident date: 5/24/26 at 7:00pm. Location: Common/Dining area. Detailed incident summary: (R1) and (R2) were in the dining/common area of the facility. (R1) was in his wheelchair and (R2) attempted to ?move' him a little. (R1) swung at (R2) and struck (R2) open handed on the jaw. Staff witnessed the incident and immediately de-escalated and separated the two residents. Nursing staff completed an injury assessment on both individuals, there were no visible or serious injuries or trauma noted. No further incident occurred. Immediate interventions and safety actions: 1. Individuals were immediately separated. 2. Staff remained with both residents to ensure de-escalation. 3. Residents had increased monitoring to ensure separation and safety of all individuals. 4. (R1) will be on 15 minute checks. 5. Physician was notified for further assessments and treatments if needed.On 6/10/26 at 1:35pm, V3, R1's Power of Attorney, stated R1 has dementia and as a result has had issues with physical aggression. V3 stated R1 hit another resident, and V3 believed it was because the facility did not provide adequate supervision. V3 stated R1 was transferred to a smaller facility where he had lived previously and had no issues there. V3 stated he was not aware there had been an episode of R1 throwing water at another resident. On 6/11/26 at 910am, V4, Social Services Designee, stated behavior interventions for R1 included 15-minute checks, redirection, activities engagement. V4 stated she talked to R1 and R2 on multiple occasions about avoiding each other and told R1 aggression toward others was unacceptable. V4 stated R1 had periods of confusion, and R2 had developmental delays. On 6/11/26 at 10:15am, R2 stated R1 would threaten him, flip him off, he threw water on him, he tried to run over R2's toes with R1's wheelchair, would shake his fist at him, and one time he hit him. R2 said staff told him to stay away from R1. R2 stated he had been upset because he felt he could not do activities he normally enjoyed, such as cleaning tables after meals, because he needed to avoid R1. On 6/12/26 at 8:50am, V5 (LPN) stated on 5/24/26 after supper, he had been walking down the hall when V9 (CNA), alerted him that R1 hit R2. V5 stated R1 and R2 were in the activity area leading to the dining room and had been separated by staff. R2 said R1 hit him on the left cheek. V5 stated he examined R2 who had no injuries. V5 stated he notified V2, who told him to, Keep them separated. V5 stated earlier in the evening, dietary staff had asked for somebody to come get R1 out of the dining room as he was threatening R2. V5 stated R1 had been moved out into the TV area but had apparently self propelled back into the dining room. V5 stated he knows before this happened they had talked about getting R1 into a local mental health hospital, but it didn't happen for whatever reason. V5 stated R1 was sent back to his previous placement. V5 stated R1 had been known to have behaviors including hitting (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff. Interventions were to keep them separated, they told R2 to stay away from R1, but he is low functioning and doesn't always understand.On 6/11/26 at 9:10am, V4, Social Services Designee, stated R1 had been aggressive with staff, struck R2, and verbally threatened him. V4 stated she talked to R1 and R2 about avoiding each other.On 6/11/26 at 10:15am, R2 was alert and oriented to person, place, and time, but not purpose. R2 stated R1 threatened, hit him, would shake his fist at him, flipped him off, threw water on him, and tried to run over his toes with R1's wheelchair although he did not make contact. R2 stated R1 also yelled at and hit staff and yelled at other residents if he felt like they were in his personal space. R2 stated staff told him to try to stay away from R1, and this upset R2 because he couldn't do things he normally liked to do, such as clearing off the dining room tables, because R1 was always around. R2 stated the police never questioned him about R1's behavior toward him. On 6/12/26 at 8:50am, V5, Licensed Practical Nurse, stated on 5/24/26 after supper, V9, Certified Nursing Assistant, notified him R1 had hit R2. V5 stated R1 and R2 were in the activity area leading to the dining room and they had been separated by staff. R2 stated he had been hit on the left cheek, but he was not hurt, and upon exam V5 stated there were no injuries. V2 stated he notified V2, Director of Nurses, who told V5 to keep R1 and R2 separated. V5 stated he did not notify V1, Administrator. V5 stated he understood that earlier that evening, dietary staff had asked that staff remove R1 from the dining room as he was threatening R2.V5 stated R1 must have self-propelled back into the dining room. V5 stated staff told R2 multiple times to stay away from R1, but R2 is low functioning and doesn't always understand. V5 stated R1 was alert with periods of confusion and had a history of aggression toward staff and verbal aggression toward R2. On 6/12/26 at 9:00am, V6, Registered Nurse, stated on 5/24/26, V5 notified her of the altercation between R1 and R2. V6 stated she immediately notified V1 as she is the Abuse Coordinator. V6 stated V1 told V6 to, Keep them separated, that's about all she said. V6 stated she thought that R1 may have already been on 15 minute checks at that point. V6 stated R1 self-propelled throughout the facility and was alert with periods of extreme confusion. V6 stated staff had talked to R2 about staying away from R1, but as R2 was developmentally delayed, he might not have understood why he needed to stay away.On 6/12/26 at 10:15am, V1 stated she was notified about the incident between R1 and R2 immediately after it happened, and she began an investigation. V1 stated she told staff to make sure R1 and R2 stay separated and to do 15-minute checks, which V1 stated in retrospect R1 might have already been on. V1 stated she was unaware of dietary staff asking for R1 to be removed from the dining room earlier in the evening. V1 stated at no time did she consider placing R1 on one-to-one supervision as they do not have enough staff. V1 stated she did not notify the police of the physical assault. On 6/12/26 at 11:10am, V7, Dietary Aid, stated she did not witness the incident with R1 and R2, but earlier in the evening, she saw R1 with his finger in R2's face, with a mean look on R1's face, and she asked CNA staff to remove R1. V7 stated R1 obviously didn't stay out of the dining room, and he was always pretty much all over the place in his wheelchair.On 6/12/26 at 12:25pm, V9 (CNA) stated R1 was sitting in his wheelchair, and was kind of in the way of traffic. V9 stated R2 was trying to be helpful and pushed R1's wheelchair out of the way and tried to remove R1's clothing protector when R1 hit R2 in the face. V9 stated she notified R2's nurse, V5, who said to keep them separated, and she told R2 to stay away from R1. V9 stated later on she heard that dietary staff heard R1 threaten R2, but she had no firsthand knowledge of that. V9 stated she was not sure if R1 was put on 15 minute checks at that point or if he was already on them, and there were no further incidents that night. On 6/12/26 at 12:35pm, V1 stated she did not notify law enforcement of R1 hitting R2. On 6/16/26 at 11:0pm, V1 stated she was not aware of R1 throwing water on R2 as referenced above. V1 stated she did not therefore begin an abuse investigation.On 6/17/26 at 8:50am, V2 stated R1 was started on every 15-minute checks on 5/24/26 around 7-730pm after he hit R2. V2 stated prior to that R1 had been on, High frequency checks, which meant all staff are keeping eyes on him, because he was never in his room unless he was in bed asleep. V2 stated R1 remained on 15-minute checks until he was discharged . V2 stated she had been notified of the incident where R1 threw water on R2. V2 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated staff had reported to her that R1 ran over R2's toes with R1's wheelchair, but when she interviewed R2 he said R1 almost ran over his toes, and when she examined his feet there were no injuries. V2 stated she was, Upset at staff for not keeping them apart. V2 stated R2 had difficulty staying away from R1 as R2 had an intellectual disability and wanted everybody to be his friend. V2 stated one to one monitoring for R1 was never considered because they don't have enough staff, and even if overtime was offered, staff would not be willing to come in. V2 stated when residents require one to one monitoring, the family will be notified and asked to provide it. V2 stated she did not think R1's family had been asked to provide one on one, and both R1's sons were difficult to get hold of.The facility's Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure dated 2026 documented, in part, Purpose: To ensure that all of (the facility's) residents are free from abuse, neglect, misappropriation of their property, and exploitation. Procedure: 3. The facility shall review altercations from resident to resident as a potential situation of abuse. A. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to: Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, (or intimidating); Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects. 4. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report resident-to-resident physical abuse to local law enforcement for one resident (R2) of three residents reviewed for abuse in the sample of three. Findings include:An IDPH (Illinois Department of Public Health) Long Term Care Serious Injury Incident and Communicable Disease Report dated 5/24/26 documented, Incident date: 5/24/26 at 7:00pm. Location: Common/Dining area. Detailed incident summary: (R1) and (R2) were in the dining/common area of the facility. (R1) was in his wheelchair and (R2) attempted to ?move' him a little. (R1) swung at (R2) and struck (R2) open handed on the jaw. Staff witnessed the incident and immediately de escalated and separated the two residents. Nursing staff completed an injury assessment on both individuals, there were no visible or serious injuries or trauma noted. No further incident occurred. Immediate interventions and safety actions: 1. Individuals were immediately separated. 2. Staff remained with both residents to ensure de escalation. 3. Residents had increased monitoring to ensure separation and safety of all individuals. 4. (R1) will be on 15 minute checks. 5. Physician was notified for further assessments and treatments if needed.There was no documentation in either R1 or R2's record to indicate law enforcement was notified of R1 hitting R2.On 6/12/26 at 10:15am, V1 (Administrator) stated she was notified about the incident between R1 and R2 immediately after it happened, and she began an investigation. On 6/12/26 at 12:35pm, V1 stated she did not notify law enforcement of R1 hitting R2. The facility's Elder Justice Act and Reporting Suspected Crimes Policy dated 2026 stated, It is (the facility's) policy to empower and enable any and all owners, operators, employees, managers, agents or contractors of the facility (Covered Individual(s)) to make reports to the relevant authorities pursuant to the provision of the Elder Justice Act (EJA the Act) and CMS (Centers for Medicare Medicaid) regulations. The Facility will not retaliate against any Covered Individual in response to lawful acts done by the covered individual pursuant to the EJA. Abuse, (definition): The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse includes resident to resident altercations, including, but not limited to any willful action that results in physical injury, mental anguish, or pain. Pursuant to the EJA, Covered Individuals must report reasonable suspicions of a crime to the State Survey Agency and at least one local law enforcement entity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify and thoroughly investigate allegations of resident-to-resident abuse and failed to ensure residents were not at risk for further abuse for one resident (R2) of three residents reviewed for abuse in the sample of three. Findings include:R2's admission Record documented an admission Date of 12/14/25 and listed Diagnoses including Diabetes Type 2 and Depression. A Minimum Data Set, dated [DATE] documented that R2 had a BIMS (Brief Interview for Mental Status) score of a 12, indication R2 had moderately impaired cognition. R2's Care Plan dated 5/24/26 documented a problem area, I prefer to help with small chores. I helped my mother and sister for several years. I like to help to give myself a purpose, with a corresponding intervention, I understand that I am only to assist my mom (who is a resident) by pushing her wheelchair and not other residents in this facility, and problem area, I currently have an alteration to my ability to care for self and need assistance due to (being) developmentally delayed.R2's Nurses Notes documented the following:5/24/26: Resident was slapped by (R1) this evening at 19:00 (7pm). Incident was witnessed by two staff members who both stated they observed (R2) was pushing (R1) backwards in their wheelchair and (R1) reached up and slapped this resident across the left side of his face. This nurse was called and upon responding observed this resident and (R1) who struck him in the hallway with a CNA (Certified Nursing Assistant) standing between them. (R1) was still agitated and shaking his fist at this resident. This resident continued to lean in and allow his face to get near other resident's striking distance, further agitating (R1). This nurse intervened and took (R2) to the dining room. (R2) was assessed and no injuries could be determined. (R2) denied any pain. (R2) stated he was pushing (R1) out of the middle of the hall so the CNA could get through with the sit-to-stand lift, and noticed (R1) had a clothing protector in his lap, but when he went to take it, (R1) reached up and slapped him. Advised this resident to not interact with (R1) East Hall nurse was notified that (R1) had become aggressive, and that (R1) was taken to their room at 19:15 (7:15pm). Neuro(logical) checks were initiated on (R2) related to head trauma, and were consistent with resident's baseline.5/25/26: This nurse has reminded and instructed (R2) to stay away from (R1). Resident continues to go in proximity of (R1). After dinner this resident was close enough to (R1) was able to throw water on him. Again this nurse instructed (R2) to stay away from (R1),who is in wheelchair and very slow in when wheeling self. Notified (R2's) family who also reminded resident to stay out of proximity of (R1). (V2, Director of Nursing and V1, Administrator) (were) notified of incident. 9:15. Neuro checks were initiated on this resident related to head trauma, and were consistent with resident's baseline.R1's admission Record documented an admission Date of 4/3/26, a discharge date of 6/5/26, and listed Diagnoses including Chronic Kidney Disease, Osteoporosis, and Cognitive Communication Deficit. A Minimum Data Set, dated [DATE] documented that R1 had a BIMS score of a14 indicating R1 was cognitively intact.R1's Care Plan dated 5/24/26 documented a problem area, I have an alteration to my behavior- aggressive behaviors: 5/24/26 Incident involving another resident, with a corresponding intervention, 15-minute checks. R1's Wandering/Elopement Risk assessment dated [DATE] documented that R1 was at high risk for wandering and elopement.R1's Nurses Notes documented the following:5/24/26: (V5, Licensed Practical Nurse/LPN), the second nurse in the building informed this nurse that this resident that was under this nurse's care (R1) had, taken a swing at another resident (R2). (R2) was under (V5's) care. This nurse immediately took this resident (R1) back to his room and called V1, Administrator and Abuse Coordinator for this facility. Within minutes (V1) called this nurse back and clarified that this resident had actually made contact and struck (R2) in the jaw. This nurse assisted in preparing (R1) for bed and explained to (R1) that hitting was unacceptable behavior. (R1) is currently resting in bed, eyes closed and call light within easy reach.5/25/26: It was reported to this nurse from dayshift nurse, that (R1) was agitated with (R2) at supper and threw a cup of water on (R2). Also stated that (R1) ran over (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R2's) foot with wheelchair. That nurse contacted (V2, Director of Nurses) and (V8, Assistant Director of Nurses) and alerted them of occurrence. Resident placed on 15-minute checks to monitor whereabouts and behaviors. Resident removed from other resident and no behaviors are present at this time. Sitting in wheelchair drinking hot chocolate, at this time wheeling down hallway. Staff frequently visual monitoring. No behaviors present at this time.There was no documentation in R1 or R2's record to indicate an abuse investigation was started following R1 throwing water on R2. There was no documentation in either record to indicate an increased level of monitoring was implemented after this incident.An IDPH (Illinois Department of Public Health) Long Term Care Serious Injury Incident and Communicable Disease Report dated 5/24/26 documented, Incident date: 5/24/26 at 7:00pm. Location: Common/Dining area. Detailed incident summary: (R1) and (R2) were in the dining/common area of the facility. (R1) was in his wheelchair and (R2) attempted to ?move' him a little. (R1) swung at (R2) and struck (R2) open handed on the jaw. Staff witnessed the incident and immediately de escalated and separated the two residents. Nursing staff completed an injury assessment on both individuals, there were no visible or serious injuries or trauma noted. No further incident occurred. Immediate interventions and safety actions: 1. Individuals were immediately separated. 2. Staff remained with both residents to ensure de escalation. 3. Residents had increased monitoring to ensure separation and safety of all individuals. 4. (R1) will be on 15 minute checks. 5. Physician was notified for further assessments and treatments if needed.On 6/10/26 at 1:35pm, V3, R1's Power of Attorney, stated R1 has dementia and as a result has had issues with physical aggression. V3 stated R1 hit another resident, and V3 believed it was because the facility did not provide adequate supervision. V3 stated R1 was transferred to a smaller facility where he had lived previously and had no issues there. V3 stated he was not aware there had been an episode of R1 throwing water at another resident. On 6/11/26 at 910am, V4, Social Services Designee, stated behavior interventions for R1 included 15 minute checks, redirection, activities engagement. V4 stated she talked to R1 and R2 on multiple occasions about avoiding each other, and told R1 aggression toward others was unacceptable. V4 stated R1 had periods of confusion, and R2 has developmental delays. On 6/11/26 at 10:15am, R2 stated R1 would threaten him, flipped him off, he threw water on him, he tried to run over R2's toes with R1's wheelchair, would shake his fist at him, and one time he hit him. R2 said staff told him to stay away from R1. R2 stated he had been upset because he felt he could not do activities he normally enjoyed, such as cleaning tables after meals, because he needed to avoid R1. On 6/12/26 at 8:50am, V5 (LPN) stated on 5/24/26 after supper, he had been walking down the hall when V9 (CNA), alerted him that R1 hit R2. V5 stated R1 and R2 were in the activity area leading to the dining room, and had been separated by staff. R2 said R1 hit him on the left cheek. V5 stated he examined R2 who had no injuries. V5 stated he notified V2, who told him to, Keep them separated. V5 stated earlier in the evening, dietary staff had asked for somebody to come get R1 out of the dining room as he was threatening R2. V5 stated R1 had been moved out into the TV area, but had apparently self propelled back into the dining room. V5 stated he knows before this happened they had talked about getting R1 into a local mental health hospital but it didn't happen for whatever reason. V5 stated R1 was sent back to his previous placement. V5 stated R1 had been known to have behaviors including hitting staff. Interventions were to keep them separated, they told R2 to stay away from R1 but he is low functioning and doesn't always understand. On 6/11/26 at 9:10am, V4, Social Services Designee, stated R1 had been aggressive with staff, struck R2, and verbally threatened him. V4 stated she talked to R1 and R2 about avoiding each other.On 6/11/26 at 10:15am, R2 was alert and oriented to person, place, and time, but not purpose. R2 stated R1 threatened, hit him, would shake his fist at him, flipped him off, threw water on him, and tried to run over his toes with R1's wheelchair although he did not make contact. R2 stated R1 also yelled at and hit staff and yelled at other residents if he felt like they were in his personal space. R2 stated staff told him to try to stay away from R1, and this upset R2 because he couldn't do things stuff he normally liked to do, such as clearing off the dining room tables, because R1 was always around. R2 stated the police (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145760	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Rehab and Nursing	600 East Robinwood Drive Robinson, IL 62454

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	never questioned him about R1's behavior toward him. On 6/12/26 at 9:00am, V6, Registered Nurse, stated on 5/24/26, V5 notified her of the altercation between R1 and R2. V6 stated she immediately notified V1 as she is the Abuse Coordinator. V6 stated V1 told V6 to, Keep them separated, that's about all she said. V6 stated she thought that R1 may have already been on 15 minute checks at that point. V6 stated R1 self-propelled throughout the facility, and was alert with periods of extreme confusion. V6 stated staff had talked to R2 about staying away from R1, but as R2 was developmentally delayed, he might not have understood why he needed to stay away.On 6/12/26 at 10:15am, V1 stated she was notified about the incident between R1 and R2 immediately after it happened, and she began an investigation. V1 stated she told staff to make sure R1 and R2 stay separated and to do 15-minute checks, which V1 stated in retrospect R1 might have already been on. V1 stated she was unaware of dietary staff asking for R1 to be removed from the dining room earlier in the evening. V1 stated at no time did she consider placing R1 on one-to-one supervision as they do not have enough staff. V1 stated she did not notify the police of the physical assault. On 6/12/26 at 11:10am, V7, Dietary Aid, stated she did not witness the incident with R1 and R2, but earlier in the evening, she saw R1 with his finger in R2's face, with a mean look on R1's face, and she asked CNA staff to remove R1. V7 stated R1 obviously didn't stay out of the dining room, and he was always pretty much all over the place in his wheelchair.On 6/12/26 at 12:25pm, V9 (CNA) stated R1 was sitting in his wheelchair, and was kind of in the way of traffic. V9 stated R2 was trying to be helpful and pushed R1's wheelchair out of the way and tried to remove R1's clothing protector when R1 hit R2 in the face. V9 stated she notified R2's nurse, V5, who said to keep them separated, and she told R2 to stay away from R1. V9 stated later on she heard that dietary staff heard R1 threaten R2, but she had no firsthand knowledge of that. V9 stated she was not sure if R1 was put on 15 minute checks at that point or if he was already on them, and there were no further incidents that night. On 6/12/26 at 12:35pm, V1 stated she did not notify law enforcement of R1 hitting R2. On 6/16/26 at 11:0pm, V1 stated she was not aware of R1 throwing water on R2 as referenced above. V1 stated she did not therefore begin an abuse investigation.On 6/17/26 at 8:50am, V2 stated R1 was started on every 15-minute checks on 5/24/26 around 7-730pm after he hit R2. V2 stated prior to that R1 had been on, High frequency checks, which meant all staff are keeping eyes on him, because he was never in his room unless he was in bed asleep. V2 stated R1 remained on 15-minute checks until he was discharged . V2 stated she had been notified of the incident where R1 threw water on R2. V2 stated staff had reported to her that R1 ran over R2's toes with R1's wheelchair, but when she interviewed R2 he said R1 almost ran over his toes, and when she examined his feet there were no injuries. V2 stated she was, Upset at staff for not keeping them apart. V2 stated R2 had difficulty staying away from R1 as R2 had an intellectual disability and wanted everybody to be his friend. V2 stated one to one monitoring for R1 was never considered because they don't have enough staff, and even if overtime was offered, staff would not be willing to come in. V2 stated when residents require one to one monitoring, the family will be notified and asked to provide it. V2 stated she did not think R1's family had been asked to provide one on one, and both R1's sons were difficult to get hold of.The facility's Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure dated 2026 documented, in part, Purpose: To ensure that all of (the facility's) residents are free from abuse, neglect, misappropriation of their property, and exploitation. Procedure: 3. The facility shall review altercations from resident to resident as a potential situation of abuse. A. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to: Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, (or intimidating); Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects. 4. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility will increase enforcement action, including, but not limited to: A. Taking steps to prevent further (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	potential abuse; Reporting the alleged violation and investigation within required timeframes pursuant to federal and state statutes and regulations. See CCG 00309 Elder Justice Act Policy and Procedure; Conducting a thorough investigation of the alleged violation; (and) Taking appropriate corrective action. 9. The facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property. 12. The facility will ensure compliance with the Elder Justice Act Policy and Procedure. (See CCG 00309). 13. Response: In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility shall; A. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper time frame pursuant to this policy; B. Have evidence that all alleged violations are thoroughly investigated; C. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress; (and) D. Report the results of all investigations to the Administrator or his or her designated representative and to other officials in accordance with state law, including to the state survey agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.