STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145820	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Sterling Health and Rehab Center	435 Camden Rd Mount Sterling, IL 62353

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to de-escalate a resident's behaviors and protect a cognitively impaired resident from staff-to-resident physical abuse for one of three (R1) residents reviewed in the sample of four. These failures resulted in a staff member (V4/Registered Nurse) kicking a resident (R1), who has a diagnosis of Dementia and known physical behaviors, three times above the left hip on 11/1/25 after R1 exhibited behaviors towards V4, which caused R1 to experience psychosocial and physical harm of fear, mental anguish, and pain.These failures resulted in an Immediate Jeopardy:While the immediacy was removed on 1/3/26, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.Findings include:The facility's Abuse Policy dated 2/2025 documents, To provide guidance and procedures to the facility and staff to assure the residents remain to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. The administrator and/or designee is the facility abuse coordinator for the facility. It is the responsibility of all facility staff to assure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. It is all staff responsibility to report any allegation or witnessed abuse immediately to the administrator. 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. Procedure: Orientating and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, and misappropriation of property. Establishing and environment that promotes resident sensitivity, resident security, and prevention of mistreatment. Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attentions. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.The facility's Employee Handbook dated 11/1/25 documents, Section 5-General Standards of Conduct: (The facility) endeavors to maintain a positive work environment. Each employee plays a role in fostering this environment. Accordingly, we all must abide by certain rules of conduct, based on honesty common sense, and fair play. Because everyone may not have the same idea about proper workplace conduct, it is helpful to adopt and enforce rules all can follow. Unacceptable conduct may subject the offender to disciplinary action, up to and including discharge, in the facility's sole discretion. The following are examples of some, but not all, conduct which can be considered unacceptable: 9. Fighting, (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	threatening, or disrupting the work of others or other violations of the facility's workplace violence policy.R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired, has physical, verbal, and other behaviors, and requires partial/moderate assistance of staff for transfers.R1's current Care Plan documents R1 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Profound Intellectual Disabilities, Depression, Traumatic Brain Injury, and Vascular Dementia with Agitation. This same Care Plan documents R1 is independent with transfers, but at times requires one-person physical assistance, has a history of trauma with an intervention of the care plan team to meet to take into account strategies to provide R1 with a safe, secure, trustworthy and transparent environment through peer support, and has childlike behaviors that require staff reassurance to help R1 feel safe and secure. This care plan documents R1 will set himself on the floor and tell staff he fell in attempts to get his mother to come to the facility to see him.R1's Progress Note dated 11/1/25 at 4:23 PM and signed by V4 (RN/Registered Nurse) documents R1 put himself on a floor mat and was re-approached several times. This same note documents R1 became aggressive and pinched staff while trying to place a mechanical lift sling and (V4) called the medical Doctor and an order was given to let R1 sit on the floor to de-escalate and do 20 minutes safety checks until R1 is agreeable to get up. The facility's Incident Investigation/Administrative Summary dated 11/4/25 and signed by V1 (Administrator) documents on 11/1/25 a CNA (Certified Nursing Assistant) witnessed another staff member (V4/Registered Nurse/RN) make contact with R1's left upper leg with V4's foot, after R1 either pinched or hit V4 while staff were attempting to de-escalate R1's behaviors and assist in a transfer.V21's (CNA/Certified Nursing Assistant) written statement dated 11/1/25 documents, Today at approx. (approximately) 4:15 PM I was asked by (V4/RN/Registered Nurse) to help assist with a resident (R1) that had sat himself on the floor. She (V4) had a (mechanical lift) sling in her hand and stated that we (facility staff) would attempt to get (R1) in his chair with a (mechanical sling) from the floor. We walk in (R1's) room and (R1) immediately yelled no at (V4). (V4) approached (R1) while (R1) was yelling no at her. (V4) approached (R1) while he was yelling no and (R1) pushed (V4) aways three separate times. (V4) than in turn after the third one kicked (R1) three times while (R1) was sitting crisscross on the floor. (R1) started to cry and yelled you (V4) kicked me. I said that (V4) needed to leave (R1) alone, (V4) got frustrated at (me/V21) because I refused to put a sling under (R1) while he was being combative. I stated that it was dangerous and did not feel comfortable doing it.V23's (CNA) written statement dated 11/1/25 documents, I went into (R1's) room around 4:15 PM to help (V4) and (V21) was also in (R1's) room. (R1) was on the floor and they both were trying to get a (mechanical lift) pad underneath (R1). (R1) was agitated yelling, hitting at whoever was in front of (R1) which happened to be (V4). At one point (R1) had reached up and pinched (V4) in the leg. After (R1) did that (V4) proceeded to kick (R1) with the side of her shoes three times. (V4) was very stern in her communication with (R1) which I believe caused (R1) to be more agitated. (V21) did speak up and (told) (V4) that (R1) is very agitated, and we should not be trying to put (R1) in a sling which we then decided to leave (R1) be. I went back later maybe like ten minutes and sat down on the floor and talked to (R1) to see if I could get (R1) closer to his bed, which (R1) did end up closer. (R1) did state that he didn't like (V4) or want (V4) in his room and to shut his door so (V4) couldn't come back in.V4's Employee File documents V4 was hired on 1/30/2008.V4's Termination Form dated 11/7/25 documents V4 was terminated due to discourteous or inappropriate behavior or language to a resident (R1).On 11/2/26 at 10:30 AM R1 was sitting in bed confused and unable to answer questions appropriately.On 1/2/26 at 9:30 AM V21 (CNA) stated, On 11/1/25 sometime between lunch and supper (R1) was on the floor on a floor mat. (R1) frequently sits on the floor and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	plays and is usually a staff assist of one with a gait belt for transfers. (V4/RN) came to me and said she needed my help to get (R1) in a (mechanical lift sling) so we could get (R1) off the floor and into bed. (R1) was being very combative and did not want to be put in a sling. I did not feel comfortable with pushing (R1) to get into a sling, but (V4) kept insisting we put (R1) into a sling so we could lift (R1) into bed. (V23/CNA) was also in the room helping. While (R1) was being combative, (R1) pushed (V4) in the inner thigh and (V4) kicked (R1) three times pretty hard above the left buttock. (R1) yelled ouch and yelled at (V4), You kicked me? Get out of here! (R1) was crying and had visible tears. I made (V4) leave (R1's) room. I told (V4) no title gives you the right to kick a resident and treat a resident like that. (V4) said to me it was just a reaction to (R1) pinching her. I told (V4) kicking him three times is excessive. Kicking (R1) was definitely abuse and should not have happened. (V4) should not have kept trying to make (R1) get in a sling. That just escalated (R1's) behaviors and there was no reason for it. (V23) witnessed this too.On 1/2/26 at 10:45 AM V23 (CNA) stated, On 11/1/25 around 4:30 PM (V4) came and got me and said (R1) was sitting on the floor and (V4) needed my help to put a sling under (R1) and get him into bed. (V4) stated she was stressed earlier that day and appeared frustrated and overwhelmed. Me, (V21), and (V4) tried to put a sling under (R1) and that was making (R1) very combative. (R1) normally only requires one to maybe two staff to transfer. Instead of stepping away (V4) kept insisting we put a sling under (R1). (R1) reached out and pinched (V4) in the inner thigh. (V4) then kicked (R1) three times on the left hip. (V21) told (V4) she needed to leave (R1's) room after (V4) kicked (R1). (V4) said she kicked (R1) due to a reaction from (R1) pinching (V4). (V4) kicked (R1) kind of hard and I felt like three times was a little excessive. It was physically abuse to (R1). (R1) was crying afterwards and yelled, Ouch! She (V4) kicked me! Get her out of here! (R1) was crying and appeared to be in pain.On 1/2/26 at 11:45 AM V24 (R1's Power of Attorney) stated, (V1/Administrator) called me and reported (R1) was on the floor and a staff member reported to (V1) that the other staff member kicked (R1). (R1) puts himself on the floor at times. I have been really stressed about the situation. I was told (R1) pinched (V4) and (V4) kicked him back. (V4) and all the staff should know how to deal with difficult residents. That is why (R1) is there. (V4) should not have kicked (R1). I feel like that is physical abuse and it would have hurt (R1's) feelings and make (R1) cry, lash out, or try to defend himself. That has happened a few months ago and since then (R1) has said to me She is an idiot which I am guessing is referring to the staff member that kicked (R1). On 1/2/26 at 12:22 PM V1 (Administrator) stated, I called (V4) with the intent to terminate (V4) for acting inappropriate towards (R1). (R1) should have reapproached when (R1) was agitated and should not have kicked (R1). If (R1) was kicked three times that is considered physical abuse, even though it was a reaction from (R1) pinching (V4).On 1/2/26 at 12:26 PM V4 (Registered Nurse) stated, On 11/1/25 I had a really rough day and was very busy. When I went to (R1's) room sometime after lunch, (R1) was wet and scooting on the floor which is not abnormal. I had not worked on the unit for about a month before that. (R1) was safe and sitting on a mat. I asked the CNA's (V21 and V23) to help me, and I got a (mechanical lift) sling to get (R1) off the floor. (R1) pinched me and I brought my knee up and hit (R1) in the left hip. (V21) started to yell at me, You kicked him! This is unsafe! (R1) has behaviors and told me to go away. Looking back with (R1's) behaviors I should have left (R1) on the mat. I know (R1) had a urinary tract infection and was having behaviors.The Immediate Jeopardy started on 11/1/25 after V4 (RN) kicked R1 in the left hip three times, causing R1 to experience psychosocial and physical harm of fear, mental anguish, and pain.V1 (Administrator) and V25 (Corporate Nurse Consultant) were notified of the Immediate Jeopardy on 1/2/26 at 2:30 PM. On 1/4/26 this surveyor confirmed through interview and record review that the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility took the following actions to remove the Immediate Jeopardy: 1.V4 was suspended immediately and then terminated from employment on 11/7/25.2.V2 (Director of Nursing) completed skin assessments on R1 post incident on 11/1/25, 11/10/25, and 11/17/25 with no signs of injury related to the incident.3.V28 (Social Service Director) completed trauma risk assessments on R1 on 11/1/25, 11/7/25, 11/10/25, 11/14/25, 11/17/25, 11/19/25, 11/24/25, and 11/25/25 to ensure R1 had no concerns post incident.4.On 1/2/26 V1 and V25 (Corporate Nurse Consultant) completed all staff in-servicing regarding abuse and de-escalation training including contracted staff.5.On 1/3/26 all staff were in-serviced prior to their shift on stress management, caregiver strain, and burnout.6.On 1/2/26 the QAA (Quality Assurance and Assessment) team completed a full QAA identification and QAPI (Quality Assurance and Performance Improvement) plan of correction for R1's incident (11/1/25).7.R1's Care Plan was updated by V2 on 1/3/26 with interventions to instruct staff on what to do if R1 chooses to sit on the floor.Completion date: 1/3/26

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure physician ordered pressure ulcer treatments were transcribed to the treatment administration records and provided as ordered by the physician for one of three residents (R2) reviewed for pressure ulcers in the sample of four.Findings include:The facility's Pressure Ulcer Prevention, Identification, and Treatment Policy dated 10/16/23 documents, Purpose: To provide guidelines that will assist nursing staff in prevention, identification, and appropriate treatment of pressure ulcers. Policy: The facility will initiate an aggressive treatment program for those residents who have pressure ulcers. Responsibility: It is the responsibility of the charge nurse/designee to care for pressure areas and provide treatments as ordered. Procedure: When a pressure ulcer is identified whether in-house, or upon a resident's admission, the area will be assessed using the skin and wound assessment and initial treatment started per physician's orders.The facility's Physician Orders Policy dated 7/1/23 documents, Policy: This facility will obtain, process, and implement physician orders given by a Licensed Physician and received by a licensed nurse. Treatment Orders-When recording treatment orders, specify the treatment, location, frequency, and duration of the treatment.R2's re-admission Skin Inspection assessment dated [DATE] and signed by V32 (Agency LPN/Licensed Practical Nurse) documents R2 was re-admitted to the facility from the hospital with pressure ulcers to the right toes, left toes, coccyx, right buttock, and left buttock.R2's Hospital Discharge Orders dated 12/22/25 document orders to paint R2's bilateral toe ulcers with betadine daily, apply offloading pressure relieving boots to the feet, apply alginate and foam to all buttock ulcers and change every three days, and reposition R2 every two hours using a wedge for effective off-loading.R2's Treatment Administration Records do not include documentation of R2's pressure ulcer physician ordered treatments dated 12/22/25 being transcribed or provided to R2's bilateral buttocks, coccyx, right toes, or left toes until 12/30/25 (eight days after re-admission).On 1/2/26 at 10:50 AM R2 was lying on a low air loss mattress. V3 (Wound Nurse) provided wound cares to R2 during this time with no concerns observed during wound cares. R2 had approximately one cm (centimeter) open ulcers to the left and right buttock with redness surrounding the areas. V3 applied zinc 40 percent to the bilateral buttock areas. R2's toes had dark brown scabs to the right great toe tip, left great toe tip, left great middle toe, and the knuckle of the right big toe. V3 applied skin preparation to those areas. R2's coccyx wound was unstageable and covered in slough (dead tissue). R2's coccyx wound had a moderate amount of yellowish-reddish drainage and measured approximately four cm long by 1.8 cm wide. V3 applied a sodium hypochlorite solution soaked gauzed to the coccyx wound and covered with a dry dressing.On 1/9/26 at 1:30 PM V2 (Director of Nursing) stated, I helped (V32) with (R2's) re-admission orders on 12/22/25. It is partly my fault that (R2's) pressure ulcer treatments were missed. I did not put any treatments to (R2's) pressure ulcers on (R2's) treatment administration records. It looks like (R2) did not receive treatments to (R2's) pressure ulcers until 12/30/25. Someone should have noticed this and made sure (R2's) pressure ulcers were being treated upon re-admission [DATE]).