STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108136	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVELA AT O'FALLON	1022 EAST WESLEY DRIVE O FALLON, IL 62269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident to 2/5/2026 IL200262 295.6000 a)1)13) cited.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review, the Establishment failed to ensure residents were free of a resident to resident altercation, resulting in R1 falling and sustaining an abrasion to her back. Findings include: The Establishment provided an incident report dated 2/5/2026 that documents R2 had been in R1's room, pushed R1's walker, which made R1	A6000		

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A6000	Continued From page 1	A6000		

fall down. It further documents E3, Activities Director, heard a resident yelling for another resident to get out of her room. E3 ran to the residents room (R1's). It further documents, "Resident had her walker to try to get resident to get away from her. He (R2) got closer to (R1) and made her fall". It continues to document R1 stated she hurt her back.

The Establishment provided an incident report dated 2/5/2026 that documents R1 was on the floor in her apartment in front of her chair with her walker to the side of her. It documents, "Resident (R1) stated that she was trying to get (R2) out of her doorway, when she started to stand up and walk to shut her door, (R2) came at her and started to hit her multiple times then pushed her down". It further documents the nurse noted an abrasion to R1's lower back.

R2's Service Plan documents R2 was receiving services from contracted community sources for aggressive behaviors- Needs private sitter for aggressive behavior initiated 1/18/2026 and revised on 2/9/2026.

On 3/2/26 at 10:15 AM, E1, Executive Director, stated R1 was no longer at the establishment because they told R2's family he needed to look for other placement and they took R2 home. E1 stated no other facilities would accept R2 due to aggressive behaviors. At this time, E2, Director of Wellness, stated after the incident (R1's and R2's altercation) R2 was placed on 1:1 supervision. E2 stated R2 entered R1's room, R1 tried to "Shoo" R2 away, but he continued walking towards her. E2 stated R1 got up with her walker, fell, and had a "little red area on her back". E2 stated R2 frightened R1. E2 stated R2 had become more agitated, was moving furniture around the unit

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A6000	Continued From page 2	A6000		

and was becoming harder to redirect.

On 3/2/26 at 10:25 AM, E3 Activities Director, stated she heard a resident yell, "get out of my room". E3 stated she "took off running" to R1's room and R2 was in there. E3 stated R2 was right in front of R1 and her walker. E3 stated R1 complained of her back hurting.

On 3/2/2026 at approximately 10:30 AM, R1 was observed in her apartment, in a recliner, with her walker nearby. R1 stated she does recall "a guy" coming in her apartment, uninvited and "frightened me". R1 stated her back did get hurt, but it is better now and she feels safe.

On 3/2/26 at 10:41 AM, E4, Licensed Practical Nurse (LPN) stated she examined and spoke to R1 after she fell. E4 stated R1 stated, "He just kept coming. He pushed me". E4 stated R1 was sitting on the ground in her room and complained of her back hurting. E4 stated R2's wife was notified he would have to have a "sitter" (one to one supervision). E4 stated R2 had "sitters" the week prior due to aggression.

On 3/2/2026 at 12:07 PM, E2 stated R2 was started on 1:1 supervision on 1/17/2026 and it was discontinued on 1/25/2026.

R2's Progress Notes dated 1/15/2026 documents, "Res (resident) was seen by RCA (Resident Care Aid) moving a couch from the living room into the dining room. Another Res saw him and attempted to stop him and he grabbed her by both wrists telling her, 'No it goes there'.

R2's Progress Notes dated 1/17/2026 documents R1 became agitated with a RCA and the nurse tried to help the RCA get away from the resident.

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A6000	Continued From page 3 R1 then grabbed the nurse by both arms and "started to squeeze very hard" on her arms, as well as pushed the nurse against the "hot tables". It continues to document R1's psychiatry doctor was contacted for medication changes due to aggression and R2's wife was informed R2 would need a "sitter" 24 hours a day until aggressive behaviors were managed. R2's Progress Notes dated 1/25/2026 documents R2's psychiatry group adjusted R2's medications and R2 has not had aggression or inappropriate behavior, so R2's wife was notified the private "sitters" could be discontinued. R2's Progress Notes dated 2/5/2026 documents R2 was noted wondering out of (R1's) room and had pushed R1's walker, which made R1 fall down. It further documents, "Residents' wife called r/t (related to) resident hitting and pushing another resident". The Establishments Resident's Rights Policy documents residents of the facility have the right to be treated with dignity, respect and consideration.	A6000		