STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145406	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Randolph County Care Center	312 West Belmont Sparta, IL 62286

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on interview and record review the facility failed to notify the Power of Attorney (POA)/family of a resident who was experiencing self-harm thoughts for 1 of 3 residents (R2) reviewed for self-harm in a sample of 11. Findings Include: R2's Face Sheet, print date of 04/16/25, documented R2 had diagnoses of depression and dementia. R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 out of 15 and required supervision/touching assistance with ambulation. He wears a wander/elopement alarm daily. Section D of the MDS documented under the symptom's presence R2 was having feelings of feeling down, depressed, or feeling hopeless. Under the symptoms frequency documented he was having these feelings 12-14 days (nearly every day). R2's Care Plan, with admitted [DATE], was reviewed and had no documentation regarding R2 having a diagnosis of depression. R2's Physician Notification for Routine Orders, dated 04/10/25, sent at 12:00 PM, documented the following: Explain: Today during a conversation with (R2), he said he's upset about having to stay here and just stare at the same 4 walls. He stated, If I have to stay much longer, I will shoot myself or kill myself. While he doesn't have the means to do this, I wanted you to be aware. The document was then signed by V3, Assistant Director of Nursing (ADON). This document has a section labeled Physician's Response (if appropriate) which was blank. R2's Progress Notes were reviewed and had no documentation regarding R2 having thoughts of self-harm on 04/10/25 and no documentation the POA/family was notified. On 04/15/25 at 1:40 PM, V5, R2's POA/wife said she wasn't made aware R2 had made statements of him wanting to hurt his self. She said when she did find out later, she had to have family come over and remove all the guns from the house. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25 at 12:04 PM, V3, ADON said when someone voices self-harm they will have the social worker come and talk with them to determine if they have a plan and if they are able to carry out that plan. Then they will notify the doctor about what is going on with the resident. V3 said on the day R2 voiced self-harm she had the social worker (V19) come and talk with R2. V19 then advised V3 the doctor should be notified and so she then notified the doctor. She said she typically wouldn't make a note in the progress notes the social worker would make the note. She said she sent a fax to the doctor at the time of the incident with R2 and he didn't have access to a gun the doctor didn't give any new orders it just said noted on the fax. On 04/17/25 at 12:12 PM, V19, Social Worker said the nurse will notify her when a resident makes a statement about wanting to hurt themselves and she will go down and interview the resident and ask them what statement they made. She said she would make to a point to ask them what they intended to do and what they were going to use. She would notify the doctor of the resident's behaviors and the means the resident had to anything to hurt themselves and if the doctor wasn't the resident sent out to the ER for evaluation. V19 said she didn't interview the resident the day of the incident due to her being out of the facility at a funeral. She said the nursing staff can interview the resident also they know what to do. She said she would also notify the family of what was happening. V19 said she didn't make a note that day because she didn't talk with R2 due to her being out of the facility. On 04/17/25 at 12:24 PM, Follow up interview with V3, ADON she said V19 was here on the day of the incident. She said V19 was standing next to her (V3's) desk when they discussed what was going on with R2. She said she would expect the social worker to notify the family about the incident with R2, but she guesses she didn't. On 04/22/25 at 11:01 V1, Administrator stated she was not aware V6, Medical Director had sent an order back regarding R2 and obtaining a psychiatric evaluation. V1 said it isn't in his chart. This surveyor explained to V1 V6 was called, and he stated he fax an order back for R2 to have a psych eval. V1 said she would expect the nurses to follow the doctor's orders. V1 stated when a resident is having self-harm thoughts, she would expect the nurses to do close supervision, make sure they talk with the resident, and redirection/distraction. On 04/22/25 at 11:22 AM, during a follow-up interview with V1, V1 said the nurses are expected to call and notify the families/POA when a resident is having thoughts of self-harm. The facility's physician Notification for routine orders policy, note dated, documented L. You must always notify family/guardian/POA/representative of any incident by telephone immediately (document each attempt in nurse's notes). You must also notify above parties of any significant change in resident's condition.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on observation, interview, and record review the facility failed to supervise residents to prevent elopement for one of 9 residents (R2) reviewed for supervision to prevent elopements in the sample of 11. This failure resulted in an Immediate Jeopardy when on 4/11/25, R2, a resident with dementia, left without staff knowledge and was found 1 mile away from the facility. The Immediate Jeopardy began on 4/11/25 at 4:45 PM when the facility staff noticed the wander guard alarm was sounding at the front door. R2, with diagnosis with dementia and elopement risk, eloped from the facility and was found in a ditch along a busy road by a passerby at 5:22 PM per the police report. R2 admitted ly removed his (resident monitoring device) bracelet by filing it off with an emery board. R2 then left the facility by entering the front door code which is directly posted above the keypad on a red sign with bold white numbers. R2 continues to state he will attempt to leave the facility again. V1, Administrator, was notified of the Immediate Jeopardy on 4/17/25 at 9:05 AM. Based on observation, interview, and record review, the surveyor team could not validate the facility's abatement plan and the immediacy was not removed at the time of the exit on 4/22/25. Findings Include: R2's Diagnosis Report, dated 4/17/25, documented R2 has diagnoses including senile degeneration of the brain, dementia, anxiety disorder, depression, atherosclerotic heart disease, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus, diabetic polyneuropathy, hypertension, heart failure, hyperlipidemia, hypothyroidism, and Parkinson's disease. R2's Care Plan, undated, documented R2 uses a wheelchair for mobility, requires assistance with ADLS (Activities of Daily Living) due to his impaired balance and occasional forgetfulness secondary to diagnosis of Parkinson's disease. This care plan also documented R2 is an elopement risk related to impaired safety awareness with interventions to check (resident monitoring device) function daily and placement every shift, monitor location every 15 minutes, document wandering behavior and attempted diversional interventions. R2's care plan also documented R2 has impaired cognitive function related to forgetfulness with interventions including R2's needs assistance with all decision making. R2's Progress Note, dated 4/9/25 at 11:21 PM documented pt (patient) found without (resident monitoring device). Reapplied to RLE (right lower extremity). Explained to pt it is important to wear. Pt remains in bed watching tv. Call light within reach. Room checked no (resident monitoring device) found in pt room or pt trash can. Removed 4 butter knives and 1 metal nail file for safety reasons. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Progress Note, dated 4/11/25 at 8:00 PM documented Staff noticed (resident monitoring) alarm at front door going off at 1645 (4:45 PM). This nurse and staff did a head count in the facility and noticed resident not in room. Room checks complete by staff to locate resident without success. (resident monitoring device) located in trash can by front door. ADON (Assistant Director of Nursing) notified immediately, Administrator notified. Code yellow called. Resident's wife (POA) and daughter (emergency contact) contacted. 911 call placed at 1650 (4:50 PM). On call Dr notified. Call received from local PD (Police Department) stating resident located at 1735 (5:35 PM). Resident returned to facility by local PD with resident. Wife at facility with resident. EMS (Emergency Medical Services) refused by resident. Order for 0.5 mg Ativan IM (intramuscular) once with order to give second dose if needed after 15 minutes. Both doses of Ativan administered and effective. Resident currently in room with wife eating dinner. Continuing to monitor at this time. The facility's incident report of R2's elopement, dated 4/11/25, documented Nursing Description: staff noticed (resident monitoring) alarm at front door going off at 1645 (4:45 PM). This nurse and staff did a head count in the facility and noticed resident not in room. Room checks complete by staff to locate resident without success. (Resident monitoring device) located in trash can by front door. ADON notified immediately, Administrator notified. Code yellow called. Resident's wife and daughter contacted. 911 call placed at 1650 (4:50 PM). On call Dr. notified. Call received from (local) PD stating resident located at 1735 (5:35 PM). Resident returned to facility by (local) PD with resident. Wife at facility with resident. EMS refused by resident. Resident Description: Resident stated he was 'going home and had enough of this place.' The local Police Department Incident Report, dated 4/11/25, documented missing person, reported 4/11/25 at 17:18 (5:18 PM) by walk in, occurred at (facility address). 911 call from V20 LPN (Licensed Practical Nurse) reporting R2 has been missing for approximately 20 minutes, we found his tracking bracelet in the trash. 911 call from V21, individual who found R2, reporting I'm on (name of road) Rd, just south of the ball diamond, I just found my ex-father-in-law walking in the ditch. Officers are in route, he walked away from the facility approximately 20 minutes. I'll stay with him til they arrive. It continues, Public Narrative: Located (R2) walking along (name of road) Road and transported him back to facility. EMS received a refusal and R2 was released back to the facility staff. On 4/15/25 at 11:30 AM R2 stated he took an emery board to his (resident monitoring device) band and filed it until it came off. R2 stated he just punched in the door code that is posted directly above the keypad and started walking to his home which is located about 6 miles from the facility. R2 stated he made it about 2 miles until his legs gave out, sat down on an embankment, saw his ex-daughter in law drive by, she turned around and came back, 3 cop cars then showed up and the police helped him to stand up and then took him back to the facility. R2 stated he did not tell any facility staff he was leaving. R2 then stated If I want to get out of here, I'll get out of here. I'll take the full blame if I get caught again. R2 stated he had been running the idea of leaving around in his head for a while and had been planning how he would leave. On 4/15/25 at 1:17 PM V7 Certified Nurse Assistant, CNA, stated she was told R2 eloped from the facility, but she was not on duty when it happened because it occurred on the evening shift. V7 stated she is assigned to R2's hall today and she does not know if any interventions have been put into place for R2 to prevent him from eloping again. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/15/25 at 1:21 PM V8, Housekeeper, stated facility staff check on the residents who are high risk for elopement often and those residents have (resident wandering device) bracelets on the make the doors lock when they go near it. V8 stated she is unaware of any added precautions for R2 since he eloped last week. On 4/15/25 at 1:25 PM V9, Licensed Practical Nurse, stated she is R2's nurse today and she was not on duty when R2 eloped, but she heard about it in report. V9 stated the facility has not implemented any new interventions since the elopement including for R2 and the facility has not changed the front door code since it happened. V9 stated she was told in report R2 sustained a laceration of his arm during the elopement. V9 stated the nurses now check and chart R2's wander guard bracelet is intact once a shift. V9 stated she is not aware of the facility doing any additional checks/monitoring nor documentation for R2 since the elopement other than the once a shift charting by his assigned nurse. On 4/15/25 at 1:32 PM V10, Activity Assistant, stated the activity staff are trying to keep R2 busy since he eloped, and she is not sure of what interventions are in place to try and prevent him from further elopement other than the (resident monitoring device) and she thought someone said they were going to put him on 15-minute checks. V10 stated R2 talks about going home all the time and this morning in activities R2 stated he is getting out of here one way or another. On 4/15/25 at 1:40 PM V5, wife of R2, stated after the elopement on 4/11/25 she came to the facility and R2's nurse stated to her the facility does not have enough help and they cannot watch him 24/7. V5 stated she replied to the nurse should I get someone else to come in and watch him and the nurse replied, we can't, we don't have the help. V5 stated she was even more upset about the facility not calling her when they noticed R2 was missing. V5 stated she had her phone on, and she did not have any missed calls from the facility but then received a call from her daughter who informed her R2 was missing. V5 stated the facility called her daughter about R2 missing but did not call her. V5 stated she immediately drove to town once her daughter informed her about R2 missing. V5 stated she believes R2 was gone from the facility for at least 50 minutes, that their ex-daughter in law (V21) was driving down the road, a busy road that goes to the high school ball diamonds, and (V21) thought she saw an animal in the ditch, that she turned around and realized it was R2. V5 stated R2's pants were grass stained and wet, and he had a cut on his arm, so she believes he fell at some point during the elopement. V5 stated the facility never did notify her of the elopement nor did they have a meeting with her to discuss the event. V5 stated the facility has not implemented any new precautions to keep R2 from eloping again and the facility still has the door code posted above the keypad. V5 stated R2 is usually not confused in the AM but by evening he gets confused, and he is not the same person she married [AGE] years ago due to the dementia. V5 stated R2 was very confused by the time she got to him after he eloped on 4/11/25. V5 stated she placed R2 at the facility for his safety because last fall he backed her car down to the creek, hit a tree, and totaled it due to his dementia. V5 stated she told the facility staff when he was admitted that they needed to keep a close eye on R2 because of the issues with him being forgetful. V5 stated she felt pressured to take R2 home last weekend (4/12/25 and 4/13/25) because the facility nurse stated they did not have enough staff to do 1 on 1 with him nor watch him closely. V5 stated R2 did display confusion over the weekend when he was at home. V5 stated the facility is very short staffed, even worse on the evening shift and weekends, the front office staff leave by 3:30 or 4 PM during the week and no staff are in the front to observe the front door in the evenings nor on weekends. V5 stated the facility has not changed the door code nor have they removed the sign with the door code exit since R2 eloped. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/15/25 at 2:12 PM V11 LPN stated she heard about R2's elopement and she does not know of any new interventions that have been put into place to prevent it from happening again. On 4/15/25 at 2:12 PM V12 CNA stated she was working the evening R2 eloped, the front door wander guard alarm was going off, and the staff realized R2 was missing. V12 stated R2 had a scratch on his arm once he was returned to the facility and she is not aware of any new interventions that have been added to R2's care plan to prevent him from further elopement. On 4/15/25 at 2:55 PM V1, Administrator, stated she called the Ombudsman on Monday to ask about where the facility stands with R2 wanting to leave the building and his resident rights. V1 stated R2 took his (resident monitoring device) off and threw it in the trash by the front door. V1 stated I don't consider it an elopement; we weren't going to keep him here come hell or high water. Surveyor asked what interventions have been added to R2's care plan since he eloped and V1 replied the facility is continuing to do frequent checks of R2, offering R2 distractions, and R2 has his wander guard back on. V1 stated R2 got out on 4/11/25 around 5 PM, a CNA tried to come back from lunch through the front door and it was locked so she realized something was wrong, and R2's (resident monitoring device) locked the front door since it was in the trash by the front door. V1 stated R2 obtained a small skin tear on his arm during the elopement. V1 stated R2 was found by the police sitting near the road. On 4/16/25 at 12:15 PM V7 CNA stated R2 has been talking about leaving today. V7 stated the facility management, nor anyone has told her of any new interventions to keep R2 from leaving again. On 4/16/25 at 12:18 PM R2 was observed sitting in his recliner in his room. V9, LPN was present, and surveyor witnessed R2 state to V9 I'm not going to keep doing this, I'm going to get out of here. I'm building up my strength. R2 stated, watch this and he quickly stood up from his recliner. R2 then stated my buddy drives a truck to California, and I might try and get a ride with him. My word is gold, I don't lie, if I tell you I'm going to do something then I'll do it. On 4/16/25 at 12:22 PM V14 CNA stated she is not aware of any new interventions that have been put into place to prevent R2 from eloping again. On 4/16/25 at 12:25 PM V3 Assistant Director of Nursing/Care Plan Coordinator, ADON/CPC stated she updated R2's care plan on 4/15/25 after he eloped on 4/11/25. V3 provided surveyor with a copy of R2's updated care plan that documented the added interventions of provide snacks, offer to turn on channel of a show he likes, ask if he would like a magazine to look at, or to color. On 4/16/25 at 1:20 PM Surveyor observed the red sign with white bold letters announcing PLEASE ENTER CODE BEFORE OPENING 1379* STAR still posted directly above the front door keypad. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/25 at 1:56 PM V15 CNA stated she did hear about R2's elopement, she has not been informed of any new interventions to try and prevent R2 from having another elopement. V15 stated we are keeping an eye on him. V15 stated she has worked at the facility for [AGE] years and she cannot remember the door code ever being changed, office staff leave between 3 - 4 PM and there is no staff in the front lobby to monitor the front door. V15 stated staff cannot view the front door because the double doors to the East Hall are always closed and, in her opinion, Management keeps the doors closed to prevent odors from going to the front lobby. V15 stated R2 was frequently attempting to go through the double doors to the front entrance prior to R2 eloping on 4/11/25 and the double doors are not alarmed. V2 stated R2 packed a bag today and said he is getting out of here. V15 stated sometimes she works over on evening shift, and she can see a change in R2's cognition from day shift to evening shift as he does have some sundowner's syndrome and was confused in the evenings when she stayed over. On 4/16/25 at 1:58 PM V7 CNA stated she does not know why the double doors are always closed on the East Hall, the floor staff cannot closely monitor the front door with them closed, and she assumes they are kept closed to keep the offices separated from the hall. V7 stated she has noticed a change in R2's cognition from AM to PM when she has worked day shift and stayed over on evening shift, and R2 has symptoms of sundowner's syndrome. V7 stated she observed R2 attempting to go through the double doors to the front lobby several times before his elopement this past Friday evening and R2 continues to state he is getting out of here. On 4/16/25 at 2:00 PM V14 CNA stated she has observed sundowner's symptoms in R2, he is alert and oriented in the morning but the times she has stayed over on evening shift she has noticed R2 to become confused, unsure of where he is at, and once thought he was at a grocery store. V14 stated the double doors are always closed, floor staff are not able to see the front door with it closed, and no office staff are in the front of the facility after 4 pm nor weekends. V14 stated R2 had attempted to go through the double doors multiple times prior to him getting out and he is still talking about leaving today. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/25 at 2:12 PM V13 CNA stated she was working the evening R2 eloped from the building. V13 stated she did see R2 in his room just before she went to break at approximately 3:45 PM, when she returned from break around 4:15 PM she attempted to enter the front door but could not because it was locked, and the alarm was going off. V13 stated she looked around and did not see a resident, then she called her coworker to let her in the building, coworker then let her in, and she went to the front lobby to shut the door alarm off. V13 stated as she was attempting to shut the alarm off, she saw the agency nurse for her and R2's unit trying to enter the front door as she was coming back from break. V13 stated she let the nurse in the door, and she thought she had deactivated the alarm, but it kept going off, so she said to the nurse that is strange, the alarm is still going off. V13 stated she went and told the other CNAS about the door alarm sounding and they checked the first floor 2 times then realized R2 wasn't in the building. V13 stated she went to the nurse who is an agency nurse and reported to her R2 was missing. V13 stated the agency nurse asked her who do I call and V13 then showed the nurse the list of numbers for the managers. V13 stated the front door alarm was still sounding and she noticed a wander guard in the trash can by the front entrance. V13 stated she was able to deactivate the door alarm once she removed the wander guard from the front lobby. V13 stated she does not know how long R2 was missing however she did see him shortly before she went on her break. V13 stated the staff cannot monitor the front door from the hall due to the double door always being closed. V13 stated once R2 was returned to the facility after he eloped, R2 stated to her that he was fighting with the cops, that he walked about 2 miles, he had walked through some brush, that he got himself out by putting in the 1379 door code that was posted by the keypad, and that he was only going to be at the facility for a couple more days. V13 stated as of yet no one has informed me of what we are doing to try and prevent R2 from eloping again. V13 stated she was initially working with just 1 other CNA and the agency nurse for the entire first floor until another CNA arrived later in the shift. V13 stated the shift was difficult because one of their assigned residents had fallen twice that day and her coworker was trying to keep that resident with her to prevent the resident from having anymore falls. V13 stated she nor her coworker were able to complete R2's 15-minute checks that day because there was no way to get everything done with only 2 CNAs. V13 stated it is even difficult to get everything done for the residents when they have 3 CNAS but they usually just have 2 CNAs on the first-floor unit for the evening shift. V13 stated the third CNA (V23) who was assigned to float between the first and second floors came on duty at approximately 3:30 PM and when she went on break it left 2 CNAs on the unit since the nurse was on break at about the same time as her. V13 stated R2 was not in the building when she came to work the next evening and she was told R2's wife took him home for the weekend because V16, LPN, told R2's wife V5 she had to take him home for the weekend because the facility did not have enough staff to do one on ones with R2. On 4/16/25 at 2:25 PM V3, ADON/CPC (Assistant Director of Nursing/Care Plan Coordinator), stated R2's last wandering assessment was completed on 4/4/25 and R2 was assessed as low risk for elopement. V3 stated the facility does not complete a separate elopement assessment for the residents. V3 stated the front office staff work until 4 PM and after that there is no staff in the front to monitor the door, the door is alarmed, and has a wander guard alarm. V3 stated R2's new interventions after R2 eloped is to monitor R2 one on one when he is agitated and to offer R2 diversional activities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/16/25 at 2:32 PM V16, LPN, stated she was the nurse on day shift last weekend on 4/12/25 and that R2 went home with his wife at about 1:45 PM on that Saturday. V16 stated she asked his wife, V5, to come to the facility because R2 stated to her if I get a chance I am getting out of here. V16 stated she parked her med cart by R2's door during the morning medication pass so she could monitor him and that he napped most of the morning then around lunch he said he was going home today. R2 then took his (resident monitoring device) off right before lunch and stated he was leaving so she then called V5 and updated her. V5 stated she would come and talk to R2 and stay for a while. V16 stated she then asked V5 what about when you leave, the Administrator wants to know if you can have a friend who can sit with him if you can't do it. V16 stated more or less I told her we didn't have the staff to monitor him 1 on 1. V16 stated she usually works weekends and we don't keep an eye on the front door because the double doors are closed. V16 stated she does not know why the double doors are always closed. Surveyor asked V16 what interventions have been implemented since R2 eloped and V16 replied nothing really new, I remind him his son is working on a plan for him to return home. On 4/17/25 at 11:25 AM V17, LPN, stated she was told the intervention to prevent R2 from eloping again is make sure his (resident monitoring device) is on and make sure the staff know where he is. V17 stated she works weekends, there is no staff in the front of the building on the weekends, and she does not know who monitors the front door when there is no office staff working. V17 stated staff do not have a view of the front door because the double doors are always closed between the front lobby and the hall. V17 stated she has noticed R2 does become confused later in the day. On 4/17/25 at 12:13 PM R2 stated when he walked away from the facility, he made it about 2 miles then his legs gave out, so he put his feet in the ditch, it was dry, and sat down by it. R2 stated he has 3 plans for when he leaves the facility next time and he about has his alarm band off by using his dentures. R2 then showed surveyors the band which was half separated in one section. R2 stated if they don't let me out of here in 2 weeks, I have plans of how to get out. R2 then stated his plans: 1. follow the creek, 2. take the south and east road down to the stop sign to (name of road) Road then east about 3 miles and his home is the first one on the right, 3. take the same route as last time but not when there are 2 ball games with 100 people driving by like there was when he left last time and plan 4. is on a route on property he is not familiar with so he is scared he might get lost if he goes that route. R2 stated he did not tell anyone he was leaving last time; he did not want to be found, and he has been exercising so he can make it home next time. R2 stated he hates being treated like a 3-year-old, he is depressed, he has marital problems after [AGE] years of marriage and he thinks his marriage is going to end. R2 stated he has a buddy who drives a truck to California every week so he has been thinking about getting a ride with him out there and getting a job, it might be hard at [AGE] years old to get a job, but he can get a job sweeping sidewalks. R2 stated the next time he tries to get out of the facility it will be after dark. (continued on next page)

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	145406	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Randolph County Care Center	312 West Belmont Sparta, IL 62286

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/21/25 V21, R2's ex-daughter-in-law/witness to elopement provided a written statement on 4/21/25 that documented 04/11/2025 at approximately 5:00 p.m. while on my way home from work, I was traveling north into (town) on (name of road) Road. From a distance, I noticed something ahead in the ditch that I believed may be an animal. As I drove closer, I realized it was a person. I slowed to nearly an idle as I veered slightly into the opposite lane and looked over to discover it was, in fact, a man sitting in the ditch. He turned his head slightly and I immediately recognized him to be (R2). I quickly turned around on a field road less than 20 feet ahead and drove back. I rolled my window down and yelled (R2's) name. He finally looked up at me and I asked if he was okay. He stated, I am trying to get up. I told him to stay still, and I would be right there. He seemed worried and asked where I was going. I told him I needed to pull my car off the road. Before exiting my vehicle, I called the (local) Police Department as I was aware this was not a good situation. I told the dispatcher my name, gave my location on (name of road) Road south of the ball diamonds, and stated there was a man in the ditch and I knew him to be (R2). She asked me to hold, and I heard her repeat the information I had given prior to returning to speak with me. She stated officers were on their way and I told her I did not need her to stay on the phone with me until they arrived. I exited my vehicle and began to walk across the road. (R2) looked up at me and asked, (V21?) Are you (V21)? I told him I was and began to help him from the ditch. He had mud on his pants, and I could tell they were damp from being in the ditch. Once he was up and on the side of the road, I helped him cross the road, so we were safely behind my vehicle as it is a frequently traveled road and the speed limit at that location is near the change from 55 mph to, I believe, 35 mph as it enters the city limits. Once I helped him lean against my car, I asked him, Did you go out for a stroll and wander off the beaten path? He responded he knew where he was going and asked if I would give him a ride up to the cut-off road to (name of road) Road. I told him I could not do that, and someone was on their way to help. R2 became very angry and stated, F_ _ _. You called the cops on me? I explained to him that I was afraid I would need help getting him out of the ditch and I knew they were strong guys that could help. He calmed slightly and said that was okay. He was holding a branch he had fashioned into a walking stick to remain steady and began to tap it hard on the road as he became very agitated telling me that he was not going back to that meat locker. I presumed he was talking about (the facility) as I was aware he was a resident. His tone was furious as he shared with me, they were going to take his driver's license away. I asked him where his driver's license was, and he told me it was in his wallet. While I was fully aware from observing his physical and mental condition that he should not drive, I told him that if it was in his wallet they couldn't take it unless he gave it to them and to just hang on to it in an attempt to validate his feelings. Once again, he agreed and seemed to calm down. I add these details from some of our conversation to confirm that his mood was not constant; he moved through emotions quickly. It was easy to calm him when he became agitated; however, it did not last, and he returned to discontent moments later. When the officers arrived, I observed more change in his mental status. The officers were very respectful when asking information about him such as his name. He responded confidently, My name is (R2), but everyone calls me (R2). When they asked if him and I knew each other, he stated I was his daughter-in-law. To that point, I am his former daughter-in-law, we have not interacted in over [AGE] years, and (R2) spoke as if no time had passed. When asked by the officers where he lived, (R2) responded that he lived right up at (address) Street as he pointed toward (town). I followed up talking directly to (R2) and said, I remember you and your dad built that house on (R2's prior address) Street before you built your house at (address) Road. I then looked to the officer and nodded so they were aware that was his most recent address, and they nodded back in acknowledgment. At one point, (R2) started speaking about places in (town) like where he was born, and I was able to engage in this conversation with him as I am aware of some of his history because I have known him for nearly [AGE] years. In the more than 30 minutes we were on the side of the road, the only time I noticed him speak about the present was when he spoke about his displeasure of being in (the facility). He had a fair memory of his younger past but seemed to have little recollection of the last [AGE] years, give, or take, if I were to put it on a timeline. Additionally, he was bleeding from what I observed to be a puncture wound on his right wrist. I held tissues on it firmly to stop the bleeding. A young woman arrived at some point from (the facility). I am not aware of her name. My observation of her interaction with him was not favorable. Most of the time, she referred to him as man. For example, she said, Man, we already have your tray in your room. Let's just go back so you can eat your dinner. R2 said something about it not

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's final investigation of R2's elopement, dated 4/17/25, documented R2 was admitted to (the facility) on 9/27/24. He is an [AGE] year-old gentleman with diagnosis of DM (diabetes mellitus), senile degeneration of the brain, Parkinson's disease, and COPD. It continues, on 4/11/25 at 4:45 PM facility front door alarm sounded. Facility staff responded immediately to the alarm and began code yellow procedures with head counts. R2 was not in his room. A (resident monitoring device) bracelet was found in the trash by the front door. 911 was notified at 4:50 PM. His wife was also notified. R2 was located at 5:35 PM by (local) PD (Police Department) badge #12 and brought back to facility. He sustained a small skin tear on his right wrist. R2 stated he was going home with his wife. He had shown no signs of exit seeking hours prior to this. After return to facility his (resident monitoring device) bracelet was placed, and he was comprehensively assessed and found to have no other injuries and was in good spirits. His wife took him home for an overnight visit on 4/12/25 and he returned to facility on 4/15/25 at 6:15 AM. His (resident monitoring device) bracelet was replaced, and 15-minute checks are in place. His care plan has been reviewed and updated. SSD (Social Service Director) has met with resident and his wife about alternate placement or safe discharge ho[TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to provide adequate staffing to provide supervision for 1 of 4 residents (R2) reviewed for sufficient staffing in a sample of 11. Findings include: The facility's daily assignment sheet, dated 4/11/25, documented 1 nurse, Agency Licensed Practical Nurse, LPN) and 2 Certified Nurse Assistants, CNAs, (V12, V13) were assigned to the first floor of the facility from 2:00 PM to 10:00 PM and a CNA (V28) assigned as floater for the first and second floor from 3:30 PM to 10 PM. On 4/11/25 between 4 PM and 5 PM R2, with Alzheimer's dementia eloped from the facility and was found approximately a mile away from the facility in a ditch along a busy road. It was determined that on 4/11/25 only 1 CNA (V12) was present on the first floor of the facility at times between 4 PM and 5 PM due to a CNA (V13) being on her lunch break, nurse (V20) being on break outside of the facility, and V23 float CNA working on the 2nd floor. The facility's incident report of R2's elopement, dated 4/11/25, documented Nursing Description: staff noticed wander guard alarm at front door going off at 1645 (4:45 PM). This nurse and staff did a head count in the facility and noticed resident not in room. Room checks complete by staff to locate resident without success. (resident monitoring device) located in trash can by front door. ADON (Assistant Director of Nursing) notified immediately, Administrator notified. Code yellow called. Resident's wife and daughter contacted. 911 call placed at 1650 (4:50 PM). On call Dr. notified. Call received from (local) PD (Police Department) stating resident located at 1735 (5:35 PM). Resident returned to facility by (local) PD with resident. Wife at facility with resident. On 4/15/25 at 1:40 PM V5, wife of R2, stated after the elopement on 4/11/25 she came to the facility and R2's nurse stated to her the facility does not have enough help and they cannot watch him 24/7. V5 stated she replied to the nurse should I get someone else to come in and watch him and the nurse replied, we can't, we don't have the help. V5 stated she believes R2 was gone from the facility for at least 50 minutes, that their ex-daughter in law (V21) was driving down the road, a busy road that goes to the high school ball diamonds, and (V21) thought she saw an animal in the ditch, that she turned around and realized it was R2. V5 stated R2's pants were grass stained and wet, and he had a cut on his arm, so she believes he fell at some point during the elopement. V5 stated she felt pressured to take R2 home last weekend (4/12/25 and 4/13/25) because the facility nurse stated they did not have enough staff to do 1 on 1 with him nor watch him closely. V5 stated R2 did display confusion over the weekend when he was at home. V5 stated the facility is very short staffed, even worse on the evening shift and weekends, the front office staff leave by 3:30 or 4 PM during the week and no staff are in the front to observe the front door in the evenings nor on weekends. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 2:12 PM V13 CNA stated she was working the evening R2 eloped from the building. V13 stated she did see R2 in his room just before she went to break at approximately 3:45 PM, when she returned from break around 4:15 PM she attempted to enter the front door but could not because it was locked, and the alarm was going off. V13 stated she looked around and did not see a resident, then she called her coworker to let her in the building, coworker then let her in, and she went to the front lobby to shut the door alarm off. V13 stated as she was attempting to shut the alarm off, she saw the agency nurse (V20) for her and R2's unit trying to enter the front door as she was coming back from break. V13 stated she let the nurse in the door, and she thought she had deactivated the alarm, but it kept going off, so she said to the nurse that is strange, the alarm is still going off. V13 stated she went and told the other CNAS about the door alarm sounding and they checked the first floor 2 times then realized R2 wasn't in the building. V13 stated she does not know how long R2 was missing however she did see him shortly before she went on her break. V13 stated once R2 was returned to the facility after he eloped, R2 stated to her that he was fighting with the cops, that he walked about 2 miles, he had walked through some brush, that he got himself out by putting in the 1379 door code that was posted by the keypad, and that he was only going to be at the facility for a couple more days. V13 stated she was initially working with just 1 other CNA and the agency nurse for the entire first floor until another CNA arrived later in the shift. V13 stated the shift was difficult because one of their assigned residents had fallen twice that day and her coworker was trying to keep that resident with her to prevent the resident from having anymore falls. V13 stated she nor her coworker were able to complete R2's 15-minute checks that day because there was no way to get everything done with only 2 CNAS. V13 stated it is even difficult to get everything done for the residents when they have 3 CNAS but they usually just have 2 CNAS on the first-floor unit for the evening shift. V13 stated the third CNA (V23) who was assigned to float between the first and second floors came on duty at approximately 3:30 PM and when she went on break it left 2 CNAS on the unit since the nurse was on break at about the same time as her. V13 stated R2 was not in the building when she came to work the next evening and she was told R2's wife took him home for the weekend because V16, LPN, told R2's wife V5 she had to take him home for the weekend because the facility did not have enough staff to do one on ones with R2. On 4/16/25 at 2:32 PM V16, LPN, stated she was the nurse on day shift last weekend on 4/12/25 and that R2 went home with his wife at about 1:45 PM on that Saturday. V16 stated she asked his wife, V5, to come to the facility because R2 stated to her if I get a chance I am getting out of here. V16 stated she parked her med cart by R2's door during the morning medication pass so she could monitor him and that he napped most of the morning then around lunch he said he was going home today. R2 then took his wander guard off right before lunch and stated he was leaving so she then called V5 and updated her. V5 stated she would come and talk to R2 and stay for a while. V16 stated she then asked V5 what about when you leave, the Administrator wants to know if you can have a friend who can sit with him if you can't do it. V16 stated more or less I told her we didn't have the staff to monitor him 1 on 1. The facility's investigation included a witness statement, dated 4/11/25, by V12 CNA that documented (R2) in his room when I got here. Then around 4:00 PM getting busy helping residents to get ready for dinner. Nurse told me she is going to break. I answered room [ROOM NUMBER], my co-CNA went to break too then after 3 minutes the alarm is off, get up to check it and I see my co-CNA in the back door asking me to open. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation included a witness statement, dated 4/11/25, by V23 CNA that documented I clocked in shortly after 3:35 PM and I saw (R2) in his room wearing a long-sleeved dark shirt and dark colored pants. About 30 minutes after being at work an older gentleman walked into R2's room and visited. At about 4:50 PM, V12 came upstairs and asked for my help looking for (R2). At about 5:20 PM after searching the building I got in my car and started to drive up and down the nearby streets. At 5:30 a man said he thinks (R2) would be headed back home towards (name of road) road. As I headed that way, I saw a cop car coming towards my direction, so I flagged him down and asked if he had seen (R2). He told me they had him and to go straight about 1/4 mile. As I pulled up, I saw (R2) leaned up against a woman's car, and a cop car behind them. I got out to check on him and he was wearing 2 button down shirts, pants, and running shoes. He was carrying a long stick which he had used to walk down the street. He was holding a blood soiled napkin against his right wrist and being very adamant that he was never stepping foot into this building again. The police officer made the decision to bring him back to (the facility) and wait for (EMS) to check him out here. I followed them back here, got the nurse, and returned to work. On 4/22/25 at 9:14 AM V20, Agency LPN, stated she went outside to her car for a few minutes on 4/11/25 when R2 eloped from the facility. V20 stated when she attempted to go back into the facility after her break, but the front door was locked, and the alarm was sounding so she called the facility and asked for staff to let her in. V20 stated V13 let her in, and a visitor stated to them he thought he set the alarm off however when they tried to deactivate the alarm it would not shut off, and they discovered a wander guard was in the trash can by the front door therefore the alarm could not be deactivated until the (resident monitoring device) was removed from the area. V20 stated when she was on a short break, the float CNA (V23) was on the second-floor unit, V13 CNA was on break, and V12 CNA was working the floor but primarily keeping an eye on a resident who had fallen twice on day shift that day. 04/17/25 at 10:10 AM, V7, CNA, stated she feels like the facility does not have enough staff working daily to properly supervise the residents. She said with all of the residents who need to be 1:1 due to being a fall risk. She said sometimes it can get chaotic. On 4/22/25 at 10:54 AM V1, Administrator, stated the facility does not have a staffing policy and follows state guidelines. V1 stated they assign breaks, but they may fluctuate depending on what is going on that day, and she expects there to be at least 2 nursing department staff members to be on each floor at all times. V1 stated she was not aware that the agency nurse (V20) and CNA (V13) went on break and out of the building at the same time on the evening shift of 4/11/25 when R2 eloped from the building. On 4/22/25 at 11:03 AM V28 CNA stated the facility normally has 3 CNAs on the day shift and she feels that is sufficient. V28 then stated, I've worked the floor by myself before and that is not enough.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review the facility failed to ensure and implement an individualized plan of care for a resident experiencing psychosocial adjustment difficulty for one of one resident (R2) reviewed for psychosocial adjustment difficulties in the sample of 11. This failure resulted in harm as evidence by R2 expressing feelings of self-harm, displaying tearfulness, and wanting to leave the facility. Findings includes: R2's Face Sheet, print date of 04/16/25, documented R2 had diagnoses of depression and dementia. R2's Minimum Data Set (MDS), dated [DATE], documented R2 is cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 out of 15 and required supervision/touching assistance with ambulation. He wears a wander/elopement alarm daily. Section D of the MDS documented under the symptom's presence R2 was having feelings of feeling down, depressed, or feeling hopeless. Under the symptoms frequency documented he was having these feelings 12-14 days (nearly every day). R2's Care Plan, with admitted [DATE], was reviewed and had no documentation regarding R2 having a diagnosis of depression. R2's Physician's Orders were reviewed and had no documentation of a psychiatric evaluation being ordered. R2's Local Psychiatric Consultants report, dated 01/31/25, documented chief complaint: Routine visit for chronic care management for Parkinson's, dementia, and anxiety. R2's Physician Notification for Routine Orders, dated 04/10/25, sent at 12:00 PM, documented the following: Explain: Today during a conversation with (R2), he said he's upset about having to stay here and just stare at the same 4 walls. He stated, If I have to stay much longer, I will shoot myself or kill myself. While he doesn't have the means to do this, I wanted you to be aware. The document was then signed by V3, Assistant Director of Nursing (ADON). This document has a section labeled Physician's Response (if appropriate) which was blank. R2's Progress Notes were reviewed and documented the following: On 4/9/2025 at 11:21 PM, Behavior Note: Patient (pt) found without (resident monitoring device). Reapplied to right lower extremity (RLE). Explained to pt it is important to wear. Pt remains in bed watching television (tv). Call light within reach, room checked no (resident monitoring device) found in pt room or pt trash can. Removed 4 butter knives and 1 metal nail file for safety reasons. R2's Progress Notes had no documentation regarding R2 having thoughts of self-harm on 04/10/25 and no documentation the doctor was notified, or any orders were received. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On 4/11/2025 at 10:03 PM, documented Behavior Note: Pt in bed at this time. (Resident monitoring device) placed on left lower extremity (LLE), pt asleep, respirations even and unlabored, and no distress noted. Dressing to right forearm (FA) dry and intact. Call light within reach. Removed 1 nail file and 2 razors from room. On 4/16/2025 at 1:39 PM, documented Behavior Note: Resident noted to be up walking around with or without assistive devices this shift. No attempts to leave out of facility as of this entry. Resident stated, I'm just building up my strength. Upon checks resident noted to be sitting in room crying. This nurse sat down with resident to console him, and he just kept saying I've had it with this place, looking at the same 4 walls, I can't do it anymore. Resident reminded of the importance of not eloping again for his safety. Resident noted with ideations of leaving again, stating, When I figure it out, I will leave again. Care is ongoing. On 4/19/2025 at 1:33 PM, documented Behavior Note: Behavioral charting continues related to (r/t) increase in antipsychotic medication at bedtime (HS). Resident noted with self-harm ideals this morning, stating I'd rather be gone, then live here any longer, I don't want to be a burden to anyone, I don't know how yet, but I'm thinking of it. That Doctor yesterday told me that I cannot do anything on my own, or be by myself, all bad news. This nurse redirected resident to think positive thoughts, resident stated, thank you for being so kind! On 4/19/2025 at 9:15 PM, documented Behavior Note: Resident redirected twice after stating he's leaving this place Resident was educated on the risks of leaving and educated on safety. This nurse had a long talk with resident while wife was present about different things that upset him and make him want to leave. Resident seems to be troubled with some family issues from years ago. Resident did mention while wife was present if/when I get out of here, I'll be dead the same day because I'll kill myself. On 4/20/2025 at 3:13 PM, documented Behavior Note: Behavior monitoring continues. Resident stated, I just have to get out of here. If it didn't hurt my boy and girl, then I'd kill myself. I just can't do it here anymore, I was supposed to be here for a week, and it's been 5 months. Resident educated on the risks of suicide and the pain that it would cause his family and friends. Resident redirected to focus on the positive aspects in life. Resident currently roaming through the halls, talking to other residents at this time. (Resident monitoring device) in place on left ankle (LA), working properly. Care is ongoing. On 04/15/25 at 10:45 AM, R2 was sitting up in his wheelchair in his room, (resident monitoring device) noted to his left ankle. He said he had only been out of the facility three times in the last 5 months, and he was tired of looking at the walls. He said he took the (resident monitoring device) off his ankle and through it in the trash. R2 said he put the code in and then went out. He said the code is by the door on a sign. R2 said he had taken his wander guard off twice now. R2 said his doctor and his wife have taken his driver's license away and he isn't able to drive anymore. He said being here in the facility is like being in prison. R2 thinks he was railroaded in to coming here to the facility and he wants to go home. He stated he had a lawn to [NAME] and things to take care of. R2 said he wants to go home. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145406	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Randolph County Care Center	312 West Belmont Sparta, IL 62286

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On 04/17/25 at 10:23 AM, R2 is sitting up in his wheelchair in his room. When this surveyor talked with him, he said he had refused his shower twice today. He said he doesn't like to take a shower here the bathrooms are nasty. R2 said he will go home and take a shower at home this weekend then come back. He said he was depressed just by being here at the facility. He said he feels like he doesn't have any freedom anymore. He said he isn't happy here. R2 said he could just set here right now and cry. While talking with R2 he became tearful at times. R2 said you know what the bible says GOD doesn't give you any more than you can handle and I'm at the top of the list. He said I feel like they have me backed into the corner and you know the only thing you can do is go forward. R2 said he hasn't had an appetite lately and he thinks his wife might be running around on him. On 04/17/25 at 12:04 PM, V3, Assistant Director of Nursing, ADON said when someone voice self-harm they will have the social worker come and talk with them to determine if they have a plan and if they are able to carry out that plan. Then they will notify the doctor about what is going on with the resident. V3 said on the day R2 voiced self-harm she had the social worker (V19) come and talk with R2. V19 then advised V3 the doctor should be notified and so she then notified the doctor. She said she typically wouldn't make a note in the progress notes the social worker would make the note. She said she sent a fax to the doctor at the time of the incident with R2 and he didn't have access to a gun the doctor didn't give any new orders it just said noted on the fax. On 04/17/25 at 12:12 PM, V19, Social Worker said the nurse will notify her when a resident makes a statement about wanting to hurt themselves and she will go down and interview the resident and ask them what statement they made. She said she would make to a point to ask them what they intended to do and what they were going to use. She would notify the doctor of the resident's behaviors and the means the resident had to anything to hurt themselves and if the doctor wasn't the resident sent out to the emergency room (ER) for evaluation. V19 said she didn't interview the resident the day of the incident due to her being out of the facility at a funeral. She said the nursing staff can interview the resident also they know what to do. She said she would also notify the family of what was happening. V19 said she didn't make a note that day because she didn't talk with R2 due to her being out of the facility. On 04/21/25 at 10:15 AM, V7, Certified Nursing Assistant (CNA) said the residents have a section in their chart where you can document their behaviors. She said R2 doesn't have a specific behavior they monitor for. V7 said some of the residents do have specific behaviors they monitor for like if a resident is combative, they will monitor for that behavior. V7 said R2 doesn't have any unless it's changed. On 04/21/25 at 10:15 AM, V17, Licensed Practical Nurse (LPN) said they are doing behavior monitoring right now on R2 due to his increase in his antipsychotic medication. She said they are also doing 15-minute checks on R2 as well. On 04/21/25 at 1:49 PM, V6, Primary Care Physician said the facility did contact him regarding R2 wanting to harm his self. He said he faxed back an order for them to get a psychiatric (psych) evaluation on R2. V6 said he doesn't believe he has a copy of what his office faxed back. V6 said he would expect the nursing staff to follow his orders and would expect the psych eval. to happen. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	On 04/22/25 at 11:01 V1, Administrator stated she was not aware V6, Medical Director had sent an order back regarding R2 and obtaining a psychiatric evaluation. V1 said it isn't in his chart. This surveyor explained to V1, V6 was called, and he stated he fax an order back for R2 to have a psych eval. V1 said she would expect the nurses to follow the doctor's orders. V1 stated when a resident is having self-harm thoughts, she would expect the nurses to do close supervision, make sure they talk with the resident, and redirection/distraction. The facility's treatment/services for mental/psychosocial concerns, dated 02/05/2019, documented Intent: It is the policy of (facility) to provide Behavioral Health Services in accordance with State and Federal regulations. 1. (Facility) will ensure that, a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and /or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. 2. (Facility) will ensure that, a resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the residents clinical condition demonstrates that development of such a pattern was unavoidable. 3. A resident, who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 44556 Based on interview and record review the facility failed to ensure the Director of Nursing was part of the Quality Assessment and Assurance Committee. This failure has the potential to affect all 46 residents residing in the facility. Findings Include: The Quality Assessment and Assurance Committee attendance sheet dated 03/05/25 documented the last QAA meeting had in attendance V1, Administrator, V6, Medical Director, V40, Pharmacist, V41, Medical Records consultant, and V3, Assistant Director of Nursing (ADON). There was no Director of Nursing (DON) in attendance. On 04/29/2025 at 12:11 PM, V1, Administrator, stated the facility currently doesn't have a DON. The Quality Assurance and Performance Improvement (QAPI) policy, not dated, documented It is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment. It further documented 5. The Quality Assessment and Assurance Committee Consists at a minimum of: A. The director of nursing services; B. The Medical Director or his/her designee; C. At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and D. The infection Preventionist- effective November 28, 2019. On 04/29/2025 at 1:07 PM, V1, Administrator stated the facility's current census is 46.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49494 Based on interview and record review the facility failed to ensure nurse aides completed the required 12 hours of education per year. This has the potential to affect all 46 residents residing in the facility. Findings include: On 4/29/25 at 11:33 AM V1, Administrator, stated the facility provides education to the facility staff including Certified Nurse Assistants, CNAs, in person and the facility does not provide any online education. V1 stated she or any of the managers keep the in-service records with hours of education in one location and she will have to get the records from the department managers who did the in-services. On 4/29/25 at 11:53 AM V1 stated the facility did not provide any dementia care training for any of the CNAs in the past year, and the facility only has documentation for 3 in-services provided to CNAs in the last 12 months and those in-services were for sexual harassment, resident rights, abuse, and emergency preparedness. V1 stated the records do not have the amount of time each in-service lasted, just the dates the in-services were conducted. V1 stated the facility does not track the CNA in-service hours to ensure the CNAs receive at least 12 hours of education a year nor does the facility track what education/in-services the CNAS receive to ensure they receive the required trainings. V1 then confirmed V15 CNA, V27 CNA, V28 CNA and V38 did not received 12 hours of continuing education including dementia care within the last 12 months. V1 provided facility in-service records for the last 12 months and they document an in-service on sexual harassment was held at the facility on 11/11/24, resident rights and abuse in-service was conducted on 11/20/24, and an in-service on emergency preparedness was conducted on 4/2/25. V15, CNA, hire date of 6/26/08, documented V15 attended the 3 in-services provided by the facility in the past year. The facility in-service records do not document V15 received dementia care education nor the required 12 hours of education. V27, CNA, hire date of 5/1/23, documented V27 attended the 3 in-services provided by the facility in the past year. The facility in-service records do not document V28 received the required dementia care training nor the required 12 hours of education. V28, CNA, hire date of 3/27/23, documented V28 attended the 3 in-services provided by the facility in the past year. The facility in-service records do not document V28 received the required dementia care training nor the required 12 hours of education. V38, CNA, hire date of 10/3/23, documented V38 attended the 3 in-services provided by the facility in the past year. The facility in-service records do not document V28 received the required dementia care training nor the required 12 hours of education. On 4/29/25 at 1:07 PM V1 stated the facility does not have a policy on CNA required trainings. V1 stated the facility currently has 46 residents living at the facility.