STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145993	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coulterville Rehab & Hcc	13138 State Route 13 Coulterville, IL 62237

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure sexual abuse did not occur for 5 of 5 residents (R4, R5, R6, R7, R9) reviewed for abuse in the sample of 18. Utilizing the reasonable person concept, R4, R6 and R7, who are all cognitively impaired, would not expect to be sexually abused, causing them to feel fear, anxiety, embarrassment and anger.Findings include:R5's Physician Order Sheet (POS) dated March 2026 documents a diagnosis of Chronic atrial fibrillation unspecified, unspecified sexual dysfunction not due to a substance or known physiological condition, unspecified hearing loss, bilateral, and low back pain. R5's Care Plan with a date initiated of 1/9/2021 documents, (R5) has impaired cognitive function/dementia or impaired thought processes. R5 has a behavioral problem. Goal: (R5) will have no incidents related to identified offense through next review. Date Initiated: 09/04/2025 Revision on: 01/07/2026 Target Date: 04/15/2026. Intervention date initiated 3/19/2026: Velcro stop sign across doorway to prevent confused residents from entering room. R5's Minimum Data Set (MDS) dated [DATE] documents R5 was cognitively intact for decision making of activities of daily living.R5's MDS dated [DATE] documents R5 was moderately impaired for cognition for activities of daily living. He has impairments on both sides to his lower extremities and uses a wheelchair. R5 had three episodes where he was touching women underneath their clothing: (1) on 11/30/2024 with (R6); (2) on 1/9/2026 with (R4); and (3) on 3/26/2025 with (R7), for a total of three separate incidents. 1-R6's Physician Order Sheet (POS) dated May 2025 documents a diagnosis of hyperlipidemia, edema, depression, presence of cardia pacemaker, urinary tract infection, cystitis, disorder of bilirubin metabolism, chronic obstructive disease, chronic respiratory failure, muscle weakness, lack of coordination, abnormal posture, unsteadiness on feet and cognitive communication deficit. R6's MDS dated [DATE] documents R6 was moderately impaired for cognition for activities of daily living. She has impairment on one side of her upper extremity; and uses a wheelchair.R6's Care Plan documents, (R6) has an ADL (Activities of Daily Living) Self Care Performance Deficit. R6's Care Plan does not document anything related to abuse. R6's Health Status Notes dated 11/30/2024 documents, Note Text: Co-nurse (name-V12) informed this nurse that pt (patient) was in the DR (dining room) sitting at a table, when another pt that was sitting by her (R5) had reached over and placed his hand on pts right thigh, which was witnessed by dietary aid (V15). Dietary aid (V15) states, I immediately moved this pt away from the table and as I turned the pt around in her W/C (wheelchair), (R5) reached over and placed his hand on (R6's) left breast, and (R6) pushed his hand away. (R6) was removed from the DR (dining room) and taken to her room. Skin check done and no areas noted to right thigh or left breast, no redness, scratching and bruising noted. Pt denies pain when asked. This nurse asked pt, What happened in the DR? Pt states, that man almost touched me. V15's statement undated documents, I was in the middle of lunch serve out. I heard (R6) yelling and when I looked out, I saw (R5) grabbing (R6's) right thigh. (R5) was on the right side of (R6) facing the outside window behind (R8). I ran out there to separate them and as I was pushing (R6) out (R5) went to grab the left side of her chest and before I could stop him (R6) used both hands to push his left arm away. On 3/31/2026 at 4:58 PM, V15, Former Dietary Cook/CNA stated, (R5) has a history of grabbing (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff and residents. I remember that day because that was the first time I had seen (R5) actually grab someone. (R5) is in a wheelchair. I think he can propel himself but honestly, I am not sure. I know he barely picks his feet up. I was working at that time as a dietary cook. I am now a CNA. (R5) loves to reach for female body parts and if a female is near him, he will grab them. You cannot leave (R5) alone in the dining room. He likes to grab female breast and butts. I know he grabbed (R7) too. I remember (R6) yelling that day, and I ran out to separate them. As I was pushing (R6) (R5) went to grab her chest area and (R6) used her hands to push him away. R6's Incident Report dated 12/5/2024 documents, On 11/30/24 at approximately 12:15pm resident (R6) age [AGE], told staff that resident (R5), age [AGE], had grabbed her breast. Residents were in the dining room and immediately separated. Skin assessment done on (R6) revealed no marks to chest. At time of skin assessment, (R6) told V16, Licensed Practical Nurse (LPN), ?A man almost touched me.' Review of (V15's) statement and interview reveal that she heard (R6) yell and saw (R5) had his hand on (R6's) thigh by her knee. (V16) states as she pushed (R6) away from (R5) he raised his hand toward her chest and (R6) pushed his hand away, (V6) stated she did not see (R5) touch (R6's) breast. Interviews of alert residents in the dining room interviewed all deny seeing (R5) touch the chest area of (R6). No other staff witnessed the episode. When questioned about the episode (R5) would not respond. R5's Health Status Notes dated 11/30/2024 at 1:35 PM, documents, Note Text: dietary aide brought to this nurse's attention that resident had inappropriately touched another resident in the dining room during lunch. dietary aide stated that (R5) was sitting at the table by the kitchen serving window facing the outside window and resident (R6) was sitting on the left side of (R5) dietary aide stated that she heard yelling coming from (R6) and when she approached residents (R5) had his hand on her right thigh. Dietary aide ran out to separate residents. As dietary aide was pulling (R6) away from (R5), (R5) went to grab (R5's) left side of her chest and before aide could stop him (R6) used both hands to push (R5's) left arm away. 100 Hall nurse had asked resident what had happened, and resident stated he almost touched me this nurse asked resident what was going on resident did not respond to this nurse. Dietary manager called and reported incident to the Administrator. Dietary aide (V15) had written a statement of what had happened. Incident reported to 100 Hall nurse. (V13), Physician called, no answer, (V14, Medical Director) called and incident reported to him, no new orders at this time. (R5) to sit on restorative side in dining room per administrator.R5 Incident Report dated 12/5/2024 documents, On 11/30/2024 at approximately 12:15 PM, it was reported that resident (R6), age [AGE], told staff that resident (R5), age [AGE], had grabbed her breast. Residents were in the dining room and immediately separated. Review of (V15's) statement and interview reveal that she heard (R6) yell and saw (R5) put his hand on (R6's) right thigh by her knee. (V15) states as she pushed (R6) away from (R5), he raised his hand toward her chest and (R6's) breast and (R6) pushed his hand away. (V16) stated she did not see (R5) touch (R6's) breast. No other staff witnessed the episode. When questioned about the episode (R5) would not respond. On 12/3/2024 (R6) denied feeling unsafe at the facility and has no recall of the episode in the dining room. Social Service will meet with (R6) 2x/week for a month to ensure her psychosocial well-being. (R5) was moved to the restorative dining area for closer supervision during meals. (This is the same intervention for 12/3/2024). After full investigation (R5) was unable to state what he was doing and seemed unaware of his actions. Due to his cognitive and understanding of the event the facility determined there was no substantial abuse and have updated (R5's) care plan to include: potential for inappropriate touching of other residents with inventions to include close monitoring during the dining process in the restorative dining room, social service to ensure psychosocial review for behaviors and medication management, and behavior tracking. R5's Intervention for the incident with R5 and R6 dated 11/30/2024 documented (R5) to sit on restorative side in dining area for closer supervision. On 3/27/2026 at 9:33 AM, V1 stated (R5's) restorative dining for closer supervision is on all male dining, and there are no females. 2-R4's Minimum Data Set (MDS) dated [DATE] documents R4 has memory problems and is severely impaired for cognition for activities of daily living. She has an impairment on (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one side to her lower extremities. She uses a walker and wheelchair and needs partial to moderate assistance with most ADLS's (Activities of Daily Living). R4's Care Plan with a revision date of 1/9/2026 documents (R4) uses wheelchair for locomotion. Staff propels resident to areas of choice. (R4) is an elopement/risk wanderer. History of getting outside at her previous Long Term Care Facility and frequent exit seeking since admit to our facility. (R4) has a behavior problem; Interventions: Behavior #1: physically aggressive toward staff, approach in a calm professional manner. Explain to (R4) what you are going to assist her with and give time for (R4) to process. Attempt to redirect by talking to her while performing care. Walk away for 5-10 mins and then reattempt care. Date Initiated: 08/13/2025; with a revision date of 2/17/2026. R4's Elopement assessment dated [DATE] at 1:48 PM, documents, (R4) was at risk for elopement and documents, The resident will remain safe during periods of wandering. R4's Progress Notes dated 3/18/2026 at 10:09 AM, Note Text: administrator came to this nurse and stated that resident was in another resident's room (R5), and resident had hand down this resident's pants. This nurse filled out incident report, performed a skin assessment on resident, as well as notified NP (Nurse Practitioner) and family. R4's Initial Report dated 3/18/2026 documents, Staff observed resident to resident physical touch (R4) and (R5). R4's Final Report dated 3/18/2026 documents, The IDT (intradisciplinary Team) updated (R4's) Care Plan with the following: Resident to resident incident occurred. (R4) has no recollection of the incident and no harm was noted.V10, Certified Nursing Assistant (CNA) statement dated 3/18/2026 at 10:00 AM, documents, I walked into another room to pull out other resident. Then I see (R5) put his hand down (R4's) pants. I removed (R4) from (R5's) room. On 3/31/2026 at 5:31 PM, V10, Certified Nursing Assistant stated, I was working a different hallway, I saw (R5's) bathroom light was on, and the aid was giving a shower, so I went inside his room, and I saw (R4) in his room and saw (R5) had his hand in (R4's) pants. I removed her immediately. (R4) cannot talk and she is severely impaired and cannot tell you anything. (R4) is a wanderer and I think she wandered into his room. (R4) cannot tell you anything. (R5) can answer yes or no questions. We have been instructed to make sure there are no women around (R5). He has a history of touching staff and residents. R4 did not have any interventions documented for her incident on 3/18/2026 even though she was identified as an elopement risk and wanderer. The intervention for the incident on 3/18/2026 documents an intervention for R5 nothing for R4. Velcro stop sign on (R5's) door to prevent confused residents from wandering in. R4's Physician Order sheet (POS) for March 2026 documents a diagnosis of Alzheimer's Disease with early onset; Dementia in other diseases classified elsewhere, unspecified severity without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety. R4's Minimum Data Set (MDS) dated [DATE] documents R4 has memory problems and is severely impaired for cognition for activities of daily living. She has an impairment on one side to her lower extremities. She uses a walker and wheelchair and needs partial to moderate assistance with most ADLS's (Activities of Daily Living). R4's Care Plan with a revision date of 1/9/2026 documents (R4) uses wheelchair for locomotion. Staff propels resident to areas of choice. (R4) is an elopement/risk wanderer. History of getting outside at her previous Long Term Care Facility and frequent exit seeking since admit to our facility. On 3/27/2026 at 9:33 AM, V1, Administrator stated, This is the first incident of sexual nature we have had with (R4). She is confused and has a history of wandering. She propels herself with her feet in her wheelchair and she is exit seeking and on occasion has wandered into other residents' room. (R4) wandered into (R5's) room and while she was there (R5) put his hands down (R4's) pants. 3-R7's POS for March 2026 documents a diagnosis of unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance and anxiety; dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance, major depression disorder and anxiety. R7's MDS dated [DATE] document R7 was severely impaired with memory problems for her cognition level. She uses a wheelchair and has no impairment and needs substantial/maximal assistance for most activities of daily living. R7's Care Plan: Does not address abuse and or inappropriate resident to resident behavior. R7's Incident Report dated 3/4/2026 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documents, (R9) was observed by CNA touching (R7) inappropriately. Residents were immediately separated, and Administrator notified. (R7) is an [AGE] year-old female who admitted to the facility on [DATE]. She is wheelchair bound and propels herself about the facility. At 7:45 AM, on 2/25/26 V18, CNA observed (R9) with his right hand up the front of (R7's) shirt. (R7) was unable to answer questions related to her cognitive dysfunction. Statement from V18, Certified Nursing Assistant (CNA) dated 2/25/2026 at 8:40 AM, I took another resident out of the dining room. As I turned the corner (R9) had his right hand up and inside (R7's) shirt fondling her. I separated the residents made the nurse aware that I was leaving the floor to call the administrator.Statement from V19, Licensed Practical Nurse (LPN), I was passing out medication when (V18) came and stated that (R9) was foundling (R7's) breast by the dining room. (R9) was taken to his room and (R7) taken to sit by nurse's station, Administrator notified. R7's Progress Notes dated 2/25/2026 at 2:24 PM, Late Entry:Note Text: SSD (Social Service Director) attempt to complete a trauma informed assessment with resident. Resident was unable to participate in assessment, resident did not understand content of assessment due to cognitive deficits and answered nonsensical. R7's Health Status Notes dated 2/26/2026 at 12:39 AM, Note Text: Follow up for incident with another resident; No injuries noted.4-R9's POS for March 2026 documents a diagnosis of hyperlipidemia, obstructive sleep apnea, benign prostatic hyperplasia without lower urinary tract symptoms, anemia, altered mental status, cognitive communication deficit, abnormalities of gait, muscle weakness, abnormal posture, type 2 diabetes mellitus R9's MDS dated [DATE] document R9 was cognitively intact for decision making of activities of daily living. He has no impairment and uses a wheelchair. R9's Care Plan with date initiated of 2/25/2026 documents, (R9) has behavior problems. Behavior #1: Behavior of sexually inappropriate behavior toward peers. 1. Remove peer away from (R9). 2. Sit (R9) at an all-male table during meals. 3. Assist in escorting (R9) out of the dining room and back to his room after all meals. R9's Progress Notes dated 2/28/2026 at 12:25 PM, (R9) is alert and has no memory problems. (R9) can recall person, place and time. (R9) does not have delusions, does not have hallucinations, and decision making is not impaired. Signs of delirium: none. Other cognitive concerns: none. R9's Progress Notes do not document anything related to the incident on 2/25/2026. R9's Incident Report dated 2/25/2026 documents (R9) was interviewed by the DON (Director of Nursing) and Administrator. He stated he did not recall touching anyone. (R7) was unable to answer questions related to her cognitive function. Staff interviewed: No other staff member observed this interaction. Staff interviews also reveal no other noted behaviors from (R9). Interviews conducted with residents. No one witnessed the interaction. Residents also were asked if they had experiences any inappropriate advances by this resident, with all denying such. (R9) has not previous behaviors. The IDT reviewed the incident and the resident care plans. Based on statements from the residents involved, the facility is unable to determine the exact root cause of the incident. The IDT updated (R9's) care plan with the following: Resident will now be sitting at an all-male table for meals. Staff will assist him from the dining room to his room after meals. Behavior tracking was initiated. The IDT updated (R7s') Care Plan with the following: Resident to resident incident occurred. (R7) has no recollection of the incident and no harm was noted. Social services completed a trauma assessment noting no changes. Social Service will conduct visits with resident twice a week for two weeks. On 4/1/2026 at 5:28 PM, V18, Certified Nursing Assistant stated, I remember the incident. (R7) cannot tell you anything. I was taking a resident to the dining room and (R7) was just outside of the restorative dining room for those residents that need assistance. (R7) was parked there in her wheelchair. (R9) came along and I saw him putting his hands up her shirt and was touching her. I told (R9) he was not supposed to be doing that, and I separated them because I do not think (R7) even knew what was going on because she is so confused. I got another staff member and then I reported it. This is the first time I am aware of (R9) sexually touching anyone. I am not sure about (R7). (R7) was not in the dining room she was waiting to be taken into the dining room. R9's Intervention was documented as Resident will now be sitting at an all-male table for meals. Staff will assist him from the dining room to his room after meals. Behavior tracking was initiated.On 4/2/2026 at 12:11 PM, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V24, Medical Director stated, I would not expect any resident to be touched by staff and or any other resident in a sexual manner while residing in the facility. The Facility Abuse, Prevention and Prohibition Policy dated November 2025 documents, Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. This facility prohibits mistreatment, neglect, or abuse of residents. The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse: corporal punishment and involuntary seclusion. Sexual abuse is non-consensual sexual contact of any type with a resident including but not limited to: unwanted intimate touching of any kind, especially of breast or perineal areas.

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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	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** Based on observation, interview and record review the facility failed to provide supervision to prevent elopement. This failure resulted in R1 leaving the facility without staff knowledge and a family member (V6) observing (R1) in her wheelchair in the parking lot, with active cars coming and going. The family member (V6) brought (R1) back inside the facility. No staff knew how long (R1) was outside, or how far (R1) had gotten or where (R1) had gone.This failure resulted in an Immediate Jeopardy (IJ) which began on 3/21/2026 when R1 was able to get out of the facility unnoticed by staff and found by a family member in the parking lot in her wheelchair. Staff were unaware when R1 got out and or how long she had been outside. On 4/2/2026 at 2:28 PM, V1, Administrator, was notified of the Immediate Jeopardy. The surveyor confirmed by observations, record review and interview that the Immediate Jeopardy was removed on 4/3/2026 but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of in-service training. Findings include:On 4/2/2026 at 9:00 AM, the parking lot is off the main road of the city. The Parking lot has cars pulling in and out as visitors and family members and staff are coming and going all day in and out of the facility.On 4/2/2026 at 10:42 AM, (R1) was in her wheelchair and was attempting to open the doors to exit and was pulling on the doors. (R1) stated repeatedly (five times) she wanted to leave the building. (V23), receptionist, came and redirected her away from the door.On 4/2/2026 at 11:15 AM, (R1) pushed on the doors continuously, and the doors would not open and beeped, but the doors would not open. (R1) stated, I want to go home, I want out of here. V23 then went and redirected her away from the door. R1's Physician Order Sheet (POS) for March, 2026 documents a diagnosis of Alzheimer disease, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; anxiety disorder, unspecified anxiety disorder; unspecified psychotic disorder with delusions due to known physiological condition, major depression disorder, recurrent severe with psychotic symptoms; unspecified dementia; unspecified severity, with agitation, unspecified dementia, unspecified severity with other behavioral disturbance; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R1's Minimum Data Set (MDS) dated [DATE] document R1 was severely impaired for cognition for activities of daily living. She uses a wheelchair and needs substantial to maximal assistance for most activities of daily living. R1's MDS also documents that she has an elopement alarm, and it is used daily. R1's Care Plan does not address eloping. R1's Elopement assessment dated [DATE] documents, R1 has a desire to leave the facility, and is exit seeking with a purpose. R1 was identified as an elopement risk by the facility. R1's Progress Notes for 3/21/2026 do not document anything related to her leaving the facility unsupervised. R1's Health Status Notes dated 3/22/2026 at 2:07 PM, Note Text: Resident very tearful this afternoon, exit seeking and looking for her children. This nurse redirected resident x3 with no success. Call placed to daughter, to speak with resident. Daughter unable to soothe resident at this time. Will continue to observe. R1's Health Status Notes dated 2/2/2026 at 7:56 AM, (R1) is often tearful and agitated. (R1) often thinks she is young and that she needs to leave to go take care of her children, so she wants to go outside to the parking lot because she thinks her car is there (sometimes she is satisfied if you tell her someone in her family had to borrow it for work). On 3/24/26 at 6:27 PM, V6, Family member of R3 stated on Saturday March 21 she was here visiting her mother and that (R1) is always sitting by the door crying that she wants out of here and wants to go home. V6 stated that (R1) does not have family that visit to take her out that she knows of, so she knew she should not have been outside alone. V6 stated that with this new alarm on the door she has found that it sometimes doesn't lock after someone passes through the doors. V6 stated that she had taken R3 back to her room and needed to go get some things out of her truck and was going to bring them back in. On 3/21/2026 around 3 PM. (R1) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was outside the facility had made it halfway down/around the driveway because it is slightly downhill and she walks well with her feet while in the wheelchair. The parking lot has cars coming and going and she figured that (R1) made it approximately 20 yards, which is basically halfway around the circle drive. (V6) stated that this happened around 3 PM. stated that when she told the nurse (V16) that she found (R1) outside, alone, she replied with 'why was she outside? On 4/2/2026 at 10:39 AM, V16, Licensed Practical Nurse (LPN) stated, the day (R1) got out I was working, but I was down the hall giving treatment. I only learned of it when (V6, Family of R3) told me that (R1) had gotten out and (V6) had to help (R1) get her back inside the building. I did not know anything about it until (V6) told me. I cannot say how long (R1) was outside and/or how (R1) got out. It was crazy that day and we had to send three people out to the hospital and on top of that we had some special music, and people were coming and going. I cannot say I heard any alarms. I know (R1) had an elopement alarm on, but I do not remember it going off and/or hearing any alarms. Again, I was doing treatments, and the door was closed. As soon as I found out I reported it to (V1). (R1) is constantly trying to leave and is exit seeking. (R1) did not sign herself out that day, she is not capable of signing herself out. On 4/2/2026 at 11:00 AM, V22, Pulmonary Nurse/LPN stated, I was working the day (R1) got out of the building. I was up front and I was doing charting that day. They (Facility) had just installed a new alarm system, and I was going up and down assisting with people coming and going out of the doors. I did not see (R1) go out the doors and she does have an elopement alarm, but I do not remember hearing any alarm going off. I cannot tell you how long she was out and/or how far she got or where she went. I could only tell you (V6) brought her back in and I saw her in between the two doors when (V6) was pushing the button trying to bring her back in. We did not even know (R1) had left. I reported it to (V16) and she called (V1). (R1) is not capable of signing herself out. (R1) is very confused. On 4/2/2026 at 12:02 PM, V1, Administrator stated, I was told (R1) got out the front door. (V6) found (R1) in the parking lot and pushed her between the two doors into the vestibule and she was ringing the door alarm for staff to let her in. We believe (R1) followed a family member out the door when he was leaving. We do not have cameras. (R1) did have an elopement alarm on. We cannot say how long (R1) was outside or how far she had gotten. On 4/2/2026 at 1:28 PM, V25, Aide stated, I remember the day (R1) got out it was a Saturday. I was at the nurse's station, and I looked up and I saw (R1) out the first set of doors in between the doors with (V6). To be honest, it was a crazy day, it was super busy, call lights were going off and I just looked up and saw her coming back into the building. I know she has an elopement alarm, but I do not remember any alarm going off and the elopement alarms sound different than the door alarms. We know (R1) was outside alone and we do not know for how long and/or where she was at, only that a family member brought her back inside. On 4/2/2026 at 12:14 PM, V10, Certified Nursing Assistant stated, I was not working the day (R1) got out of the building. She is constantly exit seeking and is always going to the front door trying to get out. I am not sure how she got out and how long she was outside. On 4/2/2026 at 12:11 PM, V24, Medical Director stated, I cannot recall if they facility notified me that (R1) got out of the building without staff knowing it. (R1) is not of sound mind and she has poor safety awareness and poor judgment. It would not be good if (R1) got out of the facility and was unsupervised. She would not know how to watch for cars and/or navigate traffic. On 4/3/2026 at 10:33 AM, V2, Director of Nursing (DON) stated, I was not here when (R1) got out of the facility. When I came in on Monday, they told me (R1) had gotten out, but I was under the impression she was only between the two doors, and she had never gone outside and or family member had found her. I only learned later that a family member found (R1) and brought her back into the facility. The elopement alarm sounds different than the door alarm, but we have just gotten and new alarm systems. I would expect staff to respond to any door alarms immediately and ensure no residents ever got out. If the residents set off the alarm, I would expect staff to go and check and if they do not see any residents, I would expect them to step outside and look. If they find a resident, then they should bring them back inside the building. If they still do not see any residents than I would expect staff to start a head count and see who is missing starting with the residents at risk for elopement. I (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145993	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coulterville Rehab & Hcc	13138 State Route 13 Coulterville, IL 62237

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	would expect this to be charted. I guess it was not charted because nobody realized she got out. The Facility Elopement Policy date approved 9/25 documents, It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans. An elopement is generally characterized as any unplanned departure from a designated safe environment. For the purpose of this policy, missing resident shall be defined to mean a resident who has left the facility grounds without signing him/herself out of the facility. The Immediate Jeopardy and deficiency practice that began on 3/21/26 was corrected/removed after the facility took the following actions to correct the noncompliance. On 4/2/26 at 5:15pm the Regional Nurse Consultant completed education with the Administrator and Director of Nursing regarding the Elopement Policy and Procedure, door alarm policy with emphasis on not shutting off the alarm until reason has been identified. On 4/2/26 at 4:00pm (V1), Administrator, (V2), DON, (V26), Payroll, (V27), ADON (Assistant Director of Nursing), (V28), BOM (Business Office Manager) initiated education with all staff regarding the Elopement Policy and Procedure, door alarm policy with emphasis on not shutting off the alarm until reason has been identified and was completed 4/3/26. On 4/2/2026 at 5:53pm licensed staff completed a Head-to-Toe assessment of resident R1 noting no changes. V1, Administrator, notified Physician at 3:00pm on 4/2/26 and Responsible party on 4/2/26 at 6:38pm. Ad Hoc QAPI was completed on 4/2/26 at 3pm. The Medical Director was notified of the event. On 4/2/26 at 3:30pm, (V3) SSD (Social Service Director), (V27) ADON, and(V29), Wound Care Nurse (WCN) completed an audit of all residents' risk for elopement to ensure current. On 4/2/26 at 5:30pm V3, SSD reviewed all residents' care plans that are identified at high risk for elopement and are current. Review completed on 4/2/2026 at 6:00pm.On 4/2/2026 at 6:00pm the elopement binder was reviewed by V3 and determined to be current.V1 checked all door alarms on 4/2/26 at 4:30pm to ensure they were functioning properly. No issues were identified. Beginning 4/2/2026 V1 will complete all education for newly hired staff on the Elopement Policy, door alarm policy with emphasis on not shutting off the alarm until reason has been identified. Door alarm function is checked weekly by the maintenance director and will continue indefinitely. Beginning on 4/3/2026 (V1) will complete Elopement drills weekly for 6 weeks, followed with quarterly scheduled drills. Beginning on 4/3/2026 (V3) will conduct 5 random questionnaires for 6 weeks regarding the elopement policy and procedure and timely response to door alarms with emphasis on not shutting off the alarm until reason has been identified. Any areas of concern identified will be addressed immediately and reviewed in the QAPI process.