STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Senior Living & Rehabilitation LLC	305 N.W. 11th Street Fairfield, IL 62837

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 - Minimal harm or potential for actual harm 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 interview and record review the facility failed to implement appropriate interventions and supervision required to prevent an elopement for 1 (R2) of 3 residents reviewed for accidents in the sample of 6.The Findings Include:R2's admission Record documents an admission date to the facility of 12/01/2023 with diagnoses including Alzheimer's Disease, unspecified dementia, type 2 diabetes mellitus, chronic kidney disease, insomnia, and conductive hearing loss. R2's MDS (Minimum Data Set) with a date of 02/13/2026 documented Section C0100- Should Brief Interview for Mental Status be conducted? 0 was coded indicating that R2 is rarely / never understood and the assessment should not be completed. Section E-Behaviors documents under Wandering-Presence and Frequency documents the behavior was not exhibited. Section GG of the same MDS documents that R2 is independent for sit to lying, lying to sitting, sit to stand, walk 10 feet, walk 50 feet with two turns and walk 150 feet.R2's current Care Plan has a focus area of impaired cognitive function / dementia / Alzheimer's Disease, I often wander around throughout the facility with an initiation date of 12/18/24. Documented interventions include: are keep my routine consistent and provide a homelike environment with initiation dates of 12/18/24. A focus area with an initiated date of 04/03/2026 documents risk of elopement for R2 due to potential confusion and misidentification as a visitor. Interventions listed include post R2's photograph with notice at all facility exit doors, as approved by power of attorney with an initiation date of 4/3/26.An Elopement Risk assessment dated [DATE] documents that R2 is mobile with or without assistive device and R2 wanders. Risk factors with a check mark next to them include Alzheimer's / Dementia, Active Mental Illness, and psychotropic medication changes in the past three months. An Elopement Risk assessment dated [DATE] documents that R2 is mobile with or without assistive device and R2 wanders. Risk factors with a check mark next to them include Alzheimer's / Dementia, psychotropic medication changes in the past three months, resident stated they are leaving the facility, and resident appearance is that of a visitor. An Elopement Risk assessment dated [DATE] documents that R2 is mobile with or without assistive device, has one or more attempts to leave the facility, and wanders. Risk factors with a check mark next to them include Alzheimer's / Dementia, psychotropic medication changes in the past three months, resident stated they are leaving the facility, and resident appearance is that of a visitor.A document titled Elopement with a date of 04/02/2026 documented V11 (Hospital Employee) received a call from V14 (Community Member) at 1:06 P.M. that R2 was walking and out of the facility. V11 went to where R2 was with V14, asked him to get in the golf cart, and brought R2 back to the facility. R2 was last seen at approximately 1:05 P.M. by the nurse's station. Interventions put in place to prevent recurrence document a picture of R2 was placed at doors with permission of power of attorney, message sent out to families to be aware of surroundings when exiting / entering the building. Environmental assessment completed of doors, doors were functioning properly. R2 was assessed with no injuries, R2 never left facility property and V14 had visualization of R2 the entire time.On 04/22/2026 at 9:40 A.M. there is a sign observed posted on the entrance door with a picture of R2 on it. The sign states For the safety of our residents, please ensure the door closes securely (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behind you and that only your party exits with you. If you see the resident pictured below, who may appear to be a visitor, please do not allow him to exit with you. Thank you for your cooperation. A second sign states: Notice To ensure the safety of our residents please ensure that the door closes behind you. Please do not allow residents or anyone you don't know to exit the facility. If you have questions, please speak to the Administrator or Director of Nursing.On 04/22/2026 at 12:03 P.M., V3 (Licensed Practical Nurse) stated that R2 got out of the building on 04/02/2026. V3 stated that R2 is having an increase in behaviors and exit seeking before his elopement. V3 stated she last saw R2 right before she went to lunch on 04/02/2026 around 1:05 P.M. at the nurse's station. On 04/23/2026 at 10:52 A.M., V8 (Licensed Practical Nurse) stated R2 was out of the facility. V8 stated he was told R1 was out by trees and two hospital staff brought him back in. V8 stated once he was back in management took over and he did not do anything with it. On 04/23/2026 at 1:13 P.M., V10 (Family Member) stated R2 got out of the facility on 04/02/2026. V10 stated she gave the facility permission to post R2's picture so he does not get out again. V10 stated she is ok with them posting his picture. V10 stated the way she understood it, R2 was out walking by the road and a hospital employee's wife saw R2 and called her husband. V10 stated she thinks it was maintenance staff that got R2 in the side by side and brought him back to the facility. V10 stated R2 was not injured. V10 stated she came to the facility that day because it was R2's birthday. V10 stated when she got to the facility that is when she was made aware that R2 had gotten out of the facility. On 04/23/2026 at 1:58 P.M. V11 (Hospital Employee) stated V14 (Community Member) was delivering cards to the hospital and the nursing facility. V11 stated V14 was leaving the hospital / facility in her car, and she saw R2 walk out of the sun room door and head south. V11 stated V14 knows R2 from the community and followed R2. V11 stated V14 approached R2 and called V11 to come assist. V11 stated himself and V12 (Hospital Employee) got in the gator and drove around to the south grassy area of the hospital grounds where R2 was with V14. V11 stated R2 was headed towards a local restaurant in the grassy area of the property. V11 stated that R2 was about 25 yards form the road. V11 stated R2 was not wanting to redirect and he knew there was other staff on the golf cart. V11 contacted V15 (Hospital Employee) and V16 (Hospital Employee) to come assist. V11 stated once V15 and V16 got there, R2 was willing to go with them to the facility. V11 stated V12 and V13 took the gator to the facility to tell them and V11 rode with R2 in the golf cart. V11 stated R2 was in socks and did not have shoes on. V11 stated he believes that it was overcast that day. V11 stated he knows R2 well as they use to go to church together. V11 stated it was maybe 15 minutes from the time his wife called him until R2 was back in the facility. On 04/23/2026 at 2:15 P.M., V12 (Hospital Employee) stated he was there when V14 called V11 because R2 had gotten out of the facility. V12 stated he got in the gator with V11 and went to assist with R2. V12 stated when they got to the grassy area of the hospital grounds R2 was with V14. V12 stated once R2 was on the golf cart with V11, himself and V13 got on the gator and went to the facility. V12 stated he entered the building and asked a lady in the office if their alarms were working because R2 was outside. V12 stated the staff at the facility did not know that R2 was out of the building. V12 stated he does not remember what R2 was wearing that day. V12 stated the facility staff walked out with him and V11 had already had R2 back to the door. V12 stated as soon as R2 was back in the building he left.On 04/23/2026 at 2:20 P.M., V13 (Hospital Employee) stated he heard on the radio and came to help V11 and V12. V13 stated once R2 was in the golf cart he went with V12 to the facility to see if they knew he was out. V13 stated the facility was not aware that R2 was out of the facility. V13 stated that R2 had socks on, no shoes but did not remember what type of clothes he had on. V13 stated that R2 was on a mission to go to a local restaurant. On 04/23/2026 at 2:32 P.M., V1 (Community Liaison) stated R2's picture is on the door because he has been exit seeking. V1 stated it is her understanding that V14 occasionally volunteers at the facility and was with R2 the entire time. V1 stated V14 saw R2 exit and followed him. V1 stated that R2's wife gave the facility permission to post his picture on the doors. V1 stated the family has been offered to move R2 to a more secure facility and they refused. V1 stated during the investigation it was determined that a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visitor went out that door right before R2 went out. V1 stated the door must have been green still, which allowed R2 to exit without the alarm going off. V1 stated the door alarms were checked immediately, and all alarms were functioning appropriately. V1 stated she did not consider it an elopement because R2 was still on the facility property. V1 stated R2 was assessed, and he was not harmed in any way.On 04/23/2026 at 3:05 P.M., V2 (Director of Nursing) stated R2 does wander around the facility. V2 stated that R2 will go up to a door and if it doesn't immediately open he will move on to the next. V2 stated that staff are often 1-1 with R2 because he is always in and out of other residents' rooms.On 04/24/2026 at 9:45 A.M., V14 (Community Member) stated she was leaving the facility and left through the main entrance. V14 stated she was parked at the north end of the parking lot. V14 stated she had been at the facility delivering easter cards to the residents. V14 stated when she got in her car and pulled out she saw R2 at the exit door of the sun room and no one else around. V14 stated R2 was observed being in socks and not having shoes on. V14 stated she realized it was R2 and started following him. V14 stated she watched him walk south in the grass and through the parking lot so she parked her car and got out. V14 stated she started saying R2's name really loud to get his attention. V14 stated she called V11 to bring the golf cart to help get R2 back in. V14 stated she didn't go back in the facility because she was afraid it would have taken too long and R2 would have been in the road. V14 stated that V11 and V12 came and was finally able to convince R2 to get on the golf cart and go back to the facility.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview, and record review the facility failed to ensure residents were free of significant medication errors for 1 (R1) of 3 residents reviewed for medication administration in the sample of 6. This failure resulted in R1 not receiving his seizure medication as ordered for 5 days resulting in R1 experiencing a seizure that lasted 10 minutes and an emergency department visit.This past non-compliance occurred between 04/07/2026 and 04/13/2026.Findings Include:R1's admission Record documented an admission date to the facility of 03/14/2024 with diagnoses including chronic obstructive pulmonary disease, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, type 2 diabetes mellitus, alcoholic cirrhosis of liver, chronic pancreatitis, hypothyroidism, hyperlipidemia, and epilepsy.R1's MDS (Minimum Data Set) dated 03/13/2026 documented R1 had a BIMS (Brief Interview for Mental Status) score of 12 indicating R1 has moderate cognitive impairment.R1's Order Summary Report with a print date of 04/23/2026 documented an order for R1 to receive Lacosamide 200 mg by mouth two times a day with an order date of 05/24/2025.R1's MAR (Medication Administration Record) dated 04/01/2026 - 04/30/2026 documented on 04/07/2026 in the box for 0800 A.M. the number 6 and the box for 8:00 P.M. the number 5. On 04/08/2026 at 0800 A.M. a 6 was documented in the box and the box for 8:00 P.M. a 5 was documented. On 04/09/2026 the box for 8:00 P.M. has a 5 documented. On 04/10/2026 the box for 0800A.M. has a 6 documented and the box for 8:00 P.M. has a 6 documented. On 04/11/2026 the box for 0800 A.M. has a 6 documented and the box for 8:00 P.M. has a 7 documented in it. The Chart Codes documented on the MAR indicates 5 is Hold/See Progress Note, 6 is Other-See Progress Note, and 7 is absent from facility or Partial Administration.R1's Progress Notes dated 04/07/2026 document the following:9:57 A.M.: lacosamide 200 mg by mouth twice daily was out of stock. Notified provider and will monitor. Hard prescription was sent to pharmacy for refill and V7 (Nurse Practitioner) aware. 10:04 A.M.: R1's power of attorney was notified related to out of stock medication. 7:28 P.M.: Lacosamide 200 mg by mouth two times a day not in stock. R1's Progress Notes dated 04/08/2026 document the following:7:31 A.M.: Lacosamide 200 mg by mouth two times a day awaiting delivery.7:35 P.M.: lacosamide 200 mg by mouth two times a day awaiting medication supply. R1's Progress Note dated 04/09/2026 documents the following:7:09 P.M.: Lacosamide 200 mg by mouth two times a day awaiting from pharmacy. R1's Progress Notes dated 04/10/2026 document the following:7:55 A.M.: Lacosamide 200 mg by mouth two times a day none in stock. 7:19 P.M.: Lacosamide 200 mg by mouth two times a day, provider to send new prescription. Currently awaiting arrival. R1's Progress Notes dated 04/11/2026 document the following:7:33 A.M.: Lacosamide 200 mg by mouth two times a day not available.5:31 P.M.: R1 observed to be having a seizure in the dining room. Seizure activity lasted approximately 10 minutes. Provider was called and a new order was obtained to send R1 to the local emergency department. R1 was sent on gurney to local hospital emergency department.11:56 P.M.: R1 returned to the facility with an order to give Lacosamide. R1's records from the local hospital document an arrival date and time of 4/11/26 at 5:54 P.M. documents a diagnosis of Epileptic seizure related to external causes, not intractable, with status epilepticus. Under Assessment at 5:58 PM it documents R1 came to the Emergency Department from the facility after having a 10 minute seizure. Under the same section at 7:46 P.M. documents that R1 has seizure activity observed with left sided twitching and tremors. Seizure activity lasted approximately 12 minutes. At 10:11 P.M. documents the nurse was reviewing R1's chart and medication administration record provided by the facility, it appears R1 has not been given Lacosamide since 4/9/26 at 7:02 A.M. This medication is ordered for 200mg to be given 2 times per day, but has not been given in over 48 hours. Under Administered Medications documents R1 was given Ativan 2mg and Keppra 2000 mg intravenously. R1 discharged back to nursing facility, instructed to administer the dose of Lacosamide tonight.On 04/22/2026 at 1:22 P.M., V1 (Community Liaison) stated R1's medication not getting sent to the facility had to do with V7's (Nurse Practitioner) DEA (Drug Enforcement Administration) (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	number. V1 stated she is not sure what the exact problem was, but that was the reason R1's medication was not at the facility.On 04/22/2026 at 1:40 P.M., V7 (Nurse Practitioner) stated when the facility made her aware that R1's script for lacosamide needed renewed, she immediately sent one. V7 stated she thought the script went through but it did not. V7 stated she had her company look into why she was not able to electronically prescribe medications, and it was discovered that V7's DEA number expiration date was put in the system wrong. V7 stated the system was printing the script instead of electronically sending it to the pharmacy. V7 stated she was notified that the facility needed a new prescription for the medication but was not notified that the facility did not have the medication in stock. V7 stated if she had been made aware that the medication was not in the facility, she could have verbally approved the prescription with the pharmacy, or another practitioner from the company could have written the prescription. V7 stated it would have been addressed sooner if she had known that the facility was out of the medication. V7 stated that R1 not getting his medication could have contributed to R1 having a seizure, but R1 has other complex problems that could have caused issues.On 04/22/2026 at 2:17 P.M. R1 stated he does not remember having a seizure or having to go to the emergency department. R1 stated he was not made aware that the facility was without one of his medications.On 04/22/2026 at 4:12 P.M. V1 (Community Liaison) stated she has spoken to a representative from the pharmacy and from now on when the pharmacy receives an order and it gets kicked back to the pharmacy and will not go through, the pharmacy will email the corporate staff. V1 stated she believes this will help in not having to wait for days for the providers to send a new prescription to the pharmacy.On 04/23/2026 at 10:52 A.M. V8 (Licensed Practical Nurse) stated he called the pharmacy to see why R1 did not have his medication. V8 stated the pharmacy told him that they needed a new prescription from V7 (Nurse Practitioner). V8 stated he called V7 and informed her that there was a new prescription needed for R1's medication. V7 stated the only new order that was given to him by V7 was to monitor R1.On 04/23/2026 at 11:23 A.M. V9 (Pharmacy) stated facility sent refill request to the pharmacy. V9 stated once they received the request, they knew the medication would require a new prescription. V9 stated the pharmacy then sent a notification to V7 (Nurse Practitioner) that they needed a new prescription. V9 stated the order was then saved in the pharmacy system as pending so the staff would know to follow up on it. V9 stated pharmacy staff called V7 several times to get the new prescription. V9 stated V7 would tell pharmacy staff that it was sent. V9 stated the pharmacy checked on their end to make sure there was not a problem with the pharmacies computer system. V9 stated the pharmacy attempted to get a verbal prescription because it was acceptable with this type of medication, but was told by the receptionist no, because the providers were not responding to requests timely. V9 stated V7 and V7's office was notified several times by phone and fax that they were needing this prescription.On 04/23/2026 at 12:22 P.M. V2 (Director of Nursing) stated the facility nurses sent in a request to refill R1's lacosamide. V2 stated her understanding after investigating the situation, V7 (Nurse Practitioner) was having trouble with her DEA number and that is why the prescription was not going through when she attempted to send it to the pharmacy. V2 stated the day that V8 (Licensed Practical Nurse) reached out to V7, was the first day that R1 missed his dose. V2 stated it was her understanding that the receptionist at V7's office told V8 that the message would be sent to V7. V2 stated V7 did not give any new orders to any of the nurses besides monitoring of R1. V2 stated she called the pharmacy on 04/10/2026 because the medication was still not in the facility. V2 stated the pharmacy let her know that they needed a new prescription and the pharmacy had reached out multiple times to the provider to get the prescription. V2 stated on 04/11/2026 when the medication was still not in the facility, she messaged V7 directly. V2 stated V7 told her she is confused why the prescription is not going through because she had sent it to the pharmacy a couple times. V2 stated she did not go to the Medical Director because every time the facility called her she made it sound as if the situation was fixed. V2 stated she felt like she attempted every way possible to get the medication for R1.R1's Incident Report titled Medication Error dated 4/7/26 documented a Root Cause of Invalid DEA number from (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	provider to pharmacy. Under Intervention documents R1's medication was delivered to the facility on 4/11/26 and the issue has been resolved.On 04/24/2026 at 2:23 P.M. V1 stated the investigation showed there was an issue with the provider's DEA number. All nurses have been educated, if they put in an order for a refill and the medication does not arrive, the nurse is to notify the V1 immediately and the Medical Director. V1 stated the corporate team will be notified too, that way they can follow up with the medication to ensure timely delivery. V1 stated V2 was educated about proper notification of the Medical Director. V1 stated during the investigation it was discovered that when the facility calls the provider and they speak to the Nurse Practitioner (NP), the message does not go the to the Medical Director. V1 stated V2 was educated to make sure that the NP and the Medical Director are both notified. V1 said the facility had a QA (Quality Assurance) meeting on 04/13/2026. The medication error was discussed. It was determined that the providers company put in the wrong expiration date for V7's DEA number, which caused V7's controlled substance prescriptions to not go through. V1 said the facility has asked the pharmacy to add this medication to the backup / emergency medication box. To prevent another reoccurrence, the facility put into place that V2 will monitor medication reorder and delivery 5 times a week for 3 weeks and V2 will monitor medication carts one time a week for 3 weeks to ensure medication supply is adequate and reorder has been completed at appropriate time.The facility policy titled Medication Refill Request Policy (revised April 2007) documented the facility in conjunction with the provider and pharmacy shall ensure resident medications are readily available as possible.Prior to the survey date, the facility took the following actions to correct the non-compliance:A Quality Assurance and Performance Improvement (QAPI) meeting was held on 04/13/2026. The incident was reviewed and identification of others at risk was discussed. In attendance were V1 (Community Liaison), V2 (Director of Nursing) and V17 (Medical Director).Interventions put into place to reduce the risk of recurrence: reeducation of nursing facility personnel over notification to pharmacy and V2 if medication does not arrive at expected date completed by 04/13/2026.Monitoring / Effectiveness: V2 will use QA tool to monitor medication reorder and delivery five times a week for three weeks. V2 will review medication carts one time a week to ensure medication supply is adequate and reorder has been completed at appropriate time to ensure ordered medications remain in stock. V2 will notify V17 immediately if there is an identified prescription issue or refill issue. Any issues found will be addressed immediately and in QA meeting.