STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	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** 49663 Based on observation, interview and record review, the facility failed to provide adequate supervision for 1 of 3 residents (R1) reviewed for elopement risk in the sample of 9. This failure resulted in a cognitively impaired resident (R1) exiting the facility without staff knowledge and being found approximately two miles away from the facility. The failure required the sheriff to call an ambulance that transported R1 to a local hospital emergency room . This failure resulted in an Immediate Jeopardy, which was identified to have begun on 2/2/25 at 1:46 am when R1 exited the facility through the bird room double doors without supervision and was found by the sheriff's office approximately two miles from the facility. This past non-compliance occurred from 2/2/25 to 2/2/25. V14 (Administrator) was notified of the Immediate Jeopardy on 2/5/24 at 11:04 AM. The Surveyor confirmed by observation, record review and interview that the immediacy was removed on 2/2/25. Findings Included: R1's Facility's Admission Record documented admission to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, bipolar disorder, unspecified and Parkinson's disease without dyskinesia. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 4, indicating R1 has severe cognitive impairment. Section GG0170. Mobility in this same MDS documented R1's mobility as independent for rolling left to right, sitting to lying, sit to stand, chair to bed transfer, toilet transfer, tub/shower transfer, walking 10 feet and walking 50 feet with two turns. Section E of this MDS for Wandering-Presence and Frequency documented behaviors of this type occurred and O (Behavior not exhibited) was answered to the question has the resident wandered? R1's Facility Elopement Risk assessment dated [DATE] documented a score of 32.0 which indicated R1 is at risk of elopement. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	R1's current care plan documents R1 has a focus area of risk of elopement with diagnosis of Parkinson and ambulates: 6/24/2024 got out the door unnoticed and was picked up. Date initiated 6/24/24. Interventions in place all dated 6/24/2024 documented 15-minute checks, picture placed in wonderer book at nurses' station, and redirect R1 away from doors. R1's Facility Progress Note dated 2/2/2025 at 3:35 AM by V5 (Licensed Practical Nurse/LPN) documented, she received a call from the local sheriff's office, asking if the facility was missing R1. V5 stated, not that she was aware of, but would go check his room. V5 went to R1's room and R1 was not in there. V5 documented there had been no recent door alarm noted, except for earlier in the night in the bird room about 1 hour to 1.5 hours earlier. V5 documented the last time she recalled seeing R1 had been around 1:30 AM. R1's Facility Progress Note dated 2/2/2025 at 3:55 AM by V5 (LPN) documented she notified V10 (family) that R1 had wandered out, he didn't have any shoes and socks on because he was put to bed. V5 documented, when V10 had been notified of the incident, V10 stated What, did he escape again? V5 notified V10 that R1 had been taken to local hospital for further evaluation. R1's Local Hospital History and Physical report dated 2/2/2025 at 5:42 AM completed by V15 (Nurse Practitioner) documented under Present Illness that R1 with a history of Parkinson's disease, dementia who eloped from the skilled nursing facility where he resides was found approximately 2 miles from the facility walking in socks and a gown. The temperature outdoors was 43 degrees Fahrenheit. R1 was brought to the emergency room to be evaluated. At the time of presentation R1 was found to have an oral temperature of 97 degrees Fahrenheit. R1 also had purplish discoloration to the bottoms of both feet. R1 was chilled and shivering at the time. R1 was admitted for observation with the diagnoses of hypothermia, bilateral frostbite of feet, and Influenza. R1's Local Hospital emergency room Report by V19 (emergency room Physician) dated 2/2/2025 at 4:07 AM documents under initial comments, R1 had been found by a driver on (name of local road heading out of town) and was walking in socks and a gown. V19 documented R1 had evidence of exposure with discoloration on bottoms of both feet, abrasions noted to both hands, R1 is chilled and difficulty speaking. This same document under Course, V19 documented R1 had significant exposure to the cold, unsure how long R1 had been outside in the weather, away from the facility. V19 documented, R1 had been located approximately 2 miles away from the facility and it would take R1 quite a while to walk this distance with his medical conditions. Under Progress, V19 documented, R1's temperature was 97, but R1 felt colder than that and R1 was shivering uncontrollable. V19 documented, R1 had been initiated rewarming R1 with warmer, intravenous fluids and discoloration to feet is the most concern for frostbite. According to https://www.timeanddate.com/weather/@4237312/historic, on 2/2/25 the temperature in the city facility is located in was 45 degrees Fahrenheit at 1:52 am with a wind speed of 9 miles per hour, was 43 degrees Fahrenheit at 2:52 am with a wind speed of 8 miles per hour and was 42 degrees Fahrenheit at 3:52 am with a wind speed of 6 miles per hour. According to https://google.com/maps, R1 traveled 1.9 miles from the facility to the location he was found by police. Also, according to the website, the journey would take a minimum of 40 minutes by foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/3/2025 at 1: 30 PM, V5 (Licensed Practical Nurse/LPN) stated she had been the nurse working the night of 2/2/2025 when R1 had gotten outside of the facility. V5 stated, R1 has the tendency to wander the facility. V5 stated, on 2/2/2025 R1 had not been feeling well and been up at the nurses' station around 1:00 AM. V5 stated, V6 (Certified Nurse Aide/CNA) took R1 to his room to lay down around 1:30 AM. V5 stated, the door alarm in the bird room went off between 1:30 AM- 1:40AM. V5 stated, she looked at the camera's and did not see anyone at the front door. V5 stated, she left the door alarm on while her and V6 (CNA) walked down to the bird room door. V5 stated, when she and V6 got to the bird room, R2 had been standing by door. V5 stated, she assumed that R2 had been the resident to set the alarm off. V5 stated, she did receive a call around 3:30 AM from the local sheriff's office that R1 had been found outside of the nursing home walking down the road. V5 stated, she had not been aware that R1 had been outside the facility. V5 stated, she went down to R1's room to verify if he had been in there and R1 was not in his room or the facility. V5 stated, R1 had been transported to the local hospital via ambulance from where he was located outside the facility. V5 stated, the facility policy is when a door alarm sounds, staff is to immediately check the cameras and go to the door to investigate what caused the door alarm to sound. V5 stated, if a resident is trying to go outside or made it outside the facility, staff is to attempt to bring them back into the facility and walk outside to double check no other resident had gone outside. V5 stated, if the door alarm sounds, the staff are to do a head count of all residents to verify all residents are accounted for. V5 stated, she did not go outside when the door alarm sounded the night of 2/2/2025 to make sure no other resident had been outside and staff did not do a resident head count to verify all residents were accounted for prior to the call at 3:30 AM. V5 stated, she assumed R2 had set the door alarm off. On 2/3/2025 at 12: 40 PM, V6 (CNA) stated she did work the night that R1 did get outside the facility. V6 stated, R1 does have tendencies to wander, and exit seek. V6 stated, the bird door alarm went off around 1:30 AM -1:40 AM on 2/2/2025. V6 stated, her and V5 (LPN) went to investigate the alarm. V6 stated, the door alarm in the bird room and the front door has the same alarm with every other door having a different alarm. V6 stated, when her and V5 got to the bird room, R2 was the resident they found by the bird door while open and she and V5 assumed R2 had set the alarm off. V6 stated, there are no cameras in the bird room to verify anyone exiting the facility. V6 stated, she had laid R1 down in his room sometime around 1:30 AM on 2/2/2025. V6 stated, resident bed checks are completed every 2 hours on even hours but not documented anywhere. V6 stated, she did not have R1's side of the hall during the bed check at 2:00AM so she cannot say if he had been in his bed. V6 stated, V9 (CNA) would have completed the bed check for R1 at 2:00 AM. V6 stated, the policy stated if a door alarm goes off, staff is immediately to go to the door alarm to investigate, do a resident head count to verify that no resident had exited the building and visually look outside. V6 stated, she and V5 did not visually look outside or do a head count on residents after the door alarm in the bird room went off. V6 stated, she had been on lunch when a call came in around 3:30 AM from the local sheriff department that R1 had been found walking down the road. V6 stated, she had not been aware that R1 had gotten outside the facility. V6 stated, she is not aware of any interventions in place for R1 prior to him getting out of the facility on 2/2/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/4/2025 at 10:16 AM, V9 (CNA) stated she was working the night R1 got out of the facility on 2/2/2025. V9 stated, she was not for sure how R1 got out of the facility, but R1 is a resident who does seek exits and wanders the facility. V9 stated, R1 had been known to get outside the facility on multiple occasions. V9 stated the door alarm went off while she had been helping another resident and V5 (LPN) and V6 (CNA) responded to the door alarm in the bird room. V9 stated, V6 reported to her that R2 had been the resident who set the door alarm off in the bird room. V9 stated V6 did put R1 to bed sometime after 1:00 AM. V9 stated, the alarm went off sometime after that. V9 stated, V6 reported that R2 had been the resident found at the bird room door so V5 and V6 thought it was him who had set the alarm off. V9 stated, when a door alarm goes off the facility policy stated to notify the nurse of the alarm, staff are to go to the door to see why the alarm is sounding. V9 stated, staff members are supposed to look outside to make sure no residents had gotten outside when the door alarms go off and do a resident head count to account for all residents. V9 stated, she did not do a resident head check after the door alarm went off. V9 stated resident bed checks are completed every 2 hours on even hours. V9 stated, she did the resident bed check at 2:00 AM down R1's hallway, but R1 was not in his room. V9 stated, I thought R1 had been up at the nurses' station, and I should have gone up to the nurse's station to make sure R1 was there, but I did not. V9 stated V5 received a call sometime around 3:30 AM from the local sheriff's office stating R1 had been picked up all the way down (name of local road leading out of town) and would be taken to the local hospital for further evaluation. V9 stated R1 did not have any intervention of 15 minutes checks before the incident on 2/2/2025. V9 stated there was no resident head count after the door alarm went off. On 2/5/2025 at 3:35 PM, V15 (Nurse Practitioner/NP) stated he was the provider in charge of R1 when R1 was brought into the emergency room . V15 stated R1 had been in the local emergency room for quite some time before he got to the medical floor. V15 stated, R1 arrived at the local emergency room , very cold and shivering. V15 stated, the emergency room did give R1 some warm IV (intravenous) fluids to help warm him up. V15 stated, it was his understanding that R1 had been found 2 miles away from the facility, with no shoes on. V15 stated, R1 did have a diagnosis of hypothermia based on his symptoms when he arrived but did resolve prior to R1 being discharged . V15 stated, in his opinion, you do not have to have a low body temperature to be diagnosed with hypothermia, R1 had symptoms that included shivering, being cold, discoloration to feet and had been outside for an extended time. V15 stated, R1 had been observed for frost bite as well because R1 did have some purplish discoloration to the bottoms of his feet when arriving to the local emergency room . V15 stated, this later resolved as well. V15 stated, R1 did have an injury to his left under foot that he was aware of and observed to be bruising and a blister to the area. V15 stated, R1 had been diagnosed with influenza prior to his admission for observation. V15 stated, R1 was given some Tamiflu to help with symptoms, but was not diagnosed with influenza at the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/4/2025 at 9;10 AM, V10 (Family) stated, she received a call around 4:00 AM on 2/2/2025 from the nursing facility. V10 stated, when she answered the phone, she said Please don't tell me he escaped again. V10 stated, V5 (LPN) stated R1 had been found by a passersby driver that seen him walking down (name of local road leading out of town) and called the local sheriff's office. V10 stated, R1 had been found 2 miles from the facility and about 2 driveways down from her home. V10 stated, R1 did not have any shoes or coat on at the time he was found. V10 stated, V5 did state that the facility had not been aware that R1 had gotten outside the facility. V10 stated, the local hospital did take pictures of his feet that had a blister and bruises on his left heel and a skinned-up knee. V10 stated, she had not been aware of any interventions in place for R1 prior to 2/3/2025 and R1 had gotten outside the facility, twice last summer. V10 stated, one-time last summer, R1 got outside of the building, and she had been notified that R1 was standing by the facility sign. V10 stated, another time last summer in June 2024, R1 had gotten out, a passerby in a car called her and notified her that R1 had been walking down by the local middle school road. V10 stated, at that time, she had asked the passerby to have R1 get in her car and drive him back to the facility. On 2/3/2025 at 10:52 AM, V3 (Licensed Practical Nurse/LPN) stated, if the facility had a resident who is exit seeking or attempting to leave the facility, the facility policy is to redirect the resident. V3 stated, if a resident does make it outside of the facility, a staff member should walk with the resident. V3 stated, if they cannot walk with the resident, you are to leave the door alarm on for another staff member to come and help. V3 stated, once the resident is returned to the facility, there should be a head count of residents to make sure every resident is accounted for. V3 stated, it was reported to her by V5 (Licensed Practical Nurse/LPN) when she arrived for her shift on Sunday morning (2/2/2025) at 6:00 AM that R1 did get outside of the facility on the night shift and had been found between 3:00 am and 4:00 am. V3 stated, it had been reported to her by V5 (LPN) that there had apparently been 2 residents (R1 and R2) at the bird cage double doors when the door alarm went off earlier that night. V3 stated, V5 had only been aware of R2 being witnessed in the bird room with his hands on the door when the alarm went off and V5 was unaware that R1 had gotten outside the facility. On 2/3/2025 at 12:50 PM, V7 (CNA) stated, she did work the night that R1 had gotten outside of the facility. V7 stated, she had not been working R1's hallway that night, however, she had seen R1 at the nurses' station around 1:00 AM. V7 stated, V6 (CNA) did take R1 to his room to lay down around 1:30 AM. V7 stated, resident bed checks are completed every 2 hours on even hours. V7 stated, there had been a door alarm in the bird room that went off earlier that night, but she is not sure of the time. V7 stated, if a door alarm goes off, staff are to check the door immediately, look outside, if a resident is attempting to go outside or is outside the facility then you are to attempt to talk the resident back inside. V7 stated, a resident head count is to be done when a door alarm goes off. V7 stated, around 3:30 AM, V5 (LPN) did receive a phone call from the local sheriff's office that R1 had been found walking down the road. V7 stated, V5 (LPN) did go to R1's room to verify that he had not been in there. V7 stated, R1 was not in his room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/3/2025 at 7:58 AM, V8 (CNA) stated, she was notified during report on 2/2/2025 at 6:00 AM by V6 (CNA) that R1 had gotten outside the facility on the night shift. V8 stated, it was reported to her by V6 in report that she had laid R1 down in his bed around 1:30 AM. V8 stated, V6 reported to her that the door alarm in the bird room had sounded sometime around 1:30 AM-1:40 AM. V8 stated, V5 and V6 responded to the door alarm and they found R2 at the door in the bird room. V8 stated, V6 reported around 3:30 AM, V5 received a call from the local sheriff's office that R1 had been found walking down (name of local road leading out of town) and had been taken to the local hospital for further evaluation. V8 stated, resident bed checks are to be completed every 2 hours by staff on even hours. V8 stated, if a resident is not located during every 2-hour bed check, all staff is supposed to look for that resident and notify the nurse. V8 stated, the facility policy is if a door alarm sounds, staff are to immediately check the cameras, go to the door to investigate what caused the alarm to go off, check outside to make sure no resident made it outside. V8 stated, the front door and the bird room door have the same alarm sound and there are no cameras in the bird room. V8 stated, if a door alarm sounds, after investigating the area, staff is to complete a resident head count to make sure all residents are accounted for. V8 stated, R1 does have tendency to wander the facility and exit seek. V8 stated, R1 did have 15 minutes visual checks for interventions prior to 2/2/2025 but they were never documented. On 2/4/2025 at 11:03 AM, V12 (CNA) stated, she worked the morning that R1 had gotten out of the facility. V12 stated, V9 (CNA) reported to her that R1 did get out of the facility overnight. V12 stated, V9 reported to her that R1 had been laid down in bed around 1:30 AM. V9 stated, the door alarm in the bird room sounded sometime between 1:30 AM - 1:40 AM. V12 stated, V9 reported that V5 (LPN) and V6 (CNA) did go to the bird room to investigate the door alarm and found R2 at the door. V12 stated, resident bed checks are scheduled for every 2 hours on even hours. V12 stated, if a resident is not in their bed during bed checks, the staff are to immediately start looking for the resident and notify the nurse. V12 stated, the facility policy states that when a door alarm sounds, staff are to respond immediately to the alarm, investigate what caused it and go outside to make sure no resident is outside the facility. V12 stated, a head count is supposed to be completed on all residents after a door alarm is set off. V12 stated, R1 does have tendency's to randomly exit seek and wander. V12 stated, R1 did not have any interventions in place prior to R1 getting outside the facility on 2/2/2025. V12 stated, R1 did not have 15-minute visual checks prior to 2/3/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/4/2025 at 12:56 PM, V1 (Director of Nursing/DON) stated, V14 (Director of Operations) is the acting administrator at this time. V1 stated, she did receive a phone call from V5 (LPN) around 3:34 AM on 2/2/2025. V1 stated, V5 notified her that R1 had been found outside the facility by the local sheriff's office. V1 stated, V5 was not sure at what time R1 had gotten outside of the facility. V1 stated, she had been notified that R1 had been restless all night and had been sitting up at the nurse's station. V1 stated, V5 notified her that V6 (CNA) had laid R1 down in his room sometime before 2:00 AM but was not sure of the exact time right then. V1 stated, that was the last time R1 had been seen by staff. V1 stated, V5 notified her that the bird alarm door did alarm after 1:30 AM. V1 stated, V5 (LPN) and V6 (CNA) went to investigate the bird door alarm when they found R2 with the bird door open. V1 stated, V5 and V6 did close the door and walked R2 back to his room. V1 stated, V5 received a phone call around 3:30 AM from the local sheriff's office stating that R1 had been found down by (name of local road leading out of town). V1 stated, R1 had been taken to the local emergency room for further evaluation. V1 stated, that the facility policy stated that when a door alarm sounds, staff is supposed to go to the door to verify why the alarm is going off. V1 stated, staff are to look outside to make sure no resident had gotten outside and do a resident head count to verify all residents are accounted for. V1 stated, V5 and V6 did not go outside to make sure any resident had gotten outside, and they did not do a resident head count. V1 stated, R1 does randomly wander the facility, exit seeks and had gotten out of the facility at least two times in the Summer of 2024. V1 stated, R1 had been found by a V10's (Family) friend walking down the road on (name of local street) on 6/24/24. V1 stated, R1 had been brought back by V10's friend to the facility. V1 stated, R1 did get out of the facility a second time in the summer of 2024 but only made it to the parking lot before staff had been able to get R1 to come back in the facility. V1 stated, R1 did have interventions in place prior to 2/2/2025 that included activities, sitting up at the nurses' station, and talking to staff. V1 stated, R1 did have every 15-minute checks placed as an intervention for the 6/24/2024 elopement. V1 stated resident bed checks are completed every 2 hours on the even by staff. V1 stated, her understanding was that V9 (CNA) did not do a bed check on R1 at 2:00 AM because V6 had laid him down at 1:30 AM. V1 stated, there should have been a head count completed by staff after the door alarm went off. V1 stated, she did review the video surveillance tape from the night that R1 got outside of the facility. V1 stated, when she observed the camera, R1 was taken to his bed to lay down by V6 (CNA) around 1:35 AM on 2/2/2025. V1 stated, at 1:43 AM on 2/2/2025, R1 was seen stepping outside of his room, looking into his roommates' room across the hallway, then started walking down the hallway towards the dining room and into the bird room. V1 stated, at 1:46 AM V5 (LPN) and V6 (CNA) were observed going to the bird room to investigate the door alarm and was seen returning with R2 from the bird room. V1 stated, R1 did return from the hospital with a bruise to his right lateral heel area and abrasion to the right dorsum 1st metatarsal joint that happened during the time he had been out of the facility on 2/2/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/4/2025 at 1:30 PM, V14 (Director of Operations) stated, she had been notified by V1 sometime Sunday 2/3/2025 morning that R1 had gotten outside the facility. V14 stated, she is not for sure what time that morning she received the call. V14 stated, V1 did notify her that R1 had been laid down by V6 (CNA) sometime in the night. V14 stated, she had been notified that the bird alarm door did go off and staff did go investigate the area. V14 stated, she is not aware of what time the door alarm had gone off. V14 stated, V1 did notify her that when V5 and V6 went to investigate the alarm they found R2 standing at the bird room door. V14 stated, that V5 received a phone call around 3:30 AM from the local sheriff's office that R1 had been found outside the facility. V14 stated, the facility policy documented that staff is to complete a resident head count when the door alarms are sounded. V14 stated, staff should also be checking outside to make sure no resident made it outside the facility. V14 stated, there was no resident head count completed by staff on 2/2/2025 prior to the local sheriff's office notifying them that R1 was found outside the facility. On 2/5/2025 at 2:07 PM, V11 (Medical Director/Primary Care Physician) stated, he did visit R1 on Monday (2/3/2025) morning at the local hospital and Monday afternoon at the facility but did not document his progress note until 2/4/2025. V11 stated, his understanding after talking with V15 (Nurse Practitioner/NP), had been R1 was admitted for observation for hypothermia but did not need any treatment. V11 stated, V15 probably needed to justify keeping R1 for the observation. V11 stated, he had been notified that R1 had been found down the road from the facility but did not know how far R1 had been. V11 stated, V15 discussed the bruise noted to R1's left heel with him, but V11 did not evaluate the bottom of R1's feet. V11 said V11 had seen R1's wound pictures at the facility on 2/3/2025 when staff showed him. V11 stated, he cannot say if the blister to the right big toe came from R1's elopement from the facility. V11 stated, he had not been aware of the R1's frost bite diagnosis at the time he saw R1 in the hospital. On 2/4/2025 at 11:29 AM, R1 was noted in a regular sitting chair next to the nurse's station, alert but not oriented. V13 (LPN) removed both shoes and socks to evaluate R1's feet. Observation made of a bruise to R1's left heal approximately 2 centimeters (cm) by 1.5 centimeters, the right big toe noted to have redness the length of toe with a blister approximately 1 cm x 1 cm, and R1's right knee with a blister noted approximately 1.5 cm by 1/2 cm. V13 stated, it is her understanding that R1 returned from the hospital with these areas. R1's Facility's Wound Evaluation dated 2/3/2025 at 2:26 PM, documented #4 Abrasion to the right dorsum 1st metatarsal phalangeal joint new. area 0.19 centimeters (cm), length 0.46cm and width 0.53 cm. Picture attached with evaluation. R1's Facility's Wound Evaluation dated 2/3/2025 at 2:28 PM, documented #6 Bruise to right heel-lateral-new. area 1.85 cm, length 1.45 cm, width 1.69 cm. Picture attached with evaluation. Facility's 24 Hour Door Alarm Policy (revised 1-1-2024) under Procedure for when alarms sound: step 1. Upon hearing the alarm, the staff will visually check to see which door has alerted. Staff will then visually check that door. 2. The first available staff member will deactivate the alarm and visually check the area around the door. (immediately outside the building, surrounding rooms, etc.). 3. If there is no obvious reason for the activation of the door alarm, an immediate head check will be initiated with wander risks being counted first, then all remaining residents, until all are accounted for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	The surveyor confirmed through interview and record review that the facility took the following actions, which were initiated on 2/2/25 and completed on 2/2/25 to remove the Immediate Jeopardy: All staff, including department heads, have been educated to ensure that they are aware of policy related to resident elopement, including steps to take if alarm is sounding (doing thorough check of both inside and outside the facility along with facility head count), residents' supervision and not leaving residents unattended in potentially unsafe locations. Education was provided by the V1 (Director of Nursing) and was completed on 2/2/25, with education on-going. All staff will be educated prior to their next shift. The facility completed an elopement assessment on 12/13/24, 2/1/25 and completed another assessment on 2/3/25 for R1. R1's care plan has been updated and does identify R1 is at risk for elopements with interventions put into place. The staff have always answered the door alarms and will continue to do so. On 2/2/25, interventions were reviewed, and new interventions put into place for R1 by V20 (Chief Operations Officer) and V1 (Director of Nursing Services). Resident interventions are as follows: 1. Resident placed on 15-minute checks. 2. Resident has activity basket in his room that has DVDs and magazines about sports 3. Resident 1:1 activity increased. He likes playing bags, watching movies or TV that talk about playing ball. 4. Increase visual checks and monitoring of resident. 5. Offer activity blanket. 6. Offer resident snacks that he likes such as soft cookies and milk. 7. Resident information placed in facility wander book. 8. Resident will be redirected by offering to sit and reminisce of past times. 9. Resident will be redirected to courtyard for outdoor walks weather permitting. 10. Resident will be redirected away from doors. On 2/2/25, residents at risk for elopement were reviewed by V1 (Director of Nursing Services) to ensure person centered interventions are in place and are in careplan, to address elopement behaviors and to decrease risk. Elopement assessments are completed upon admission, quarterly, annually, and as needed for all residents by V1 (Director of Nursing Services) and/or V21 (Minimum Data Set/MDS coordinator). On 2/2/25, all alarmed exit doors were inspected and found to be in good working order by V22 (Regional Environmental Director). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146032	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Rehab & Healthcare	602 East Jackson Du Quoin, IL 62832

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	On 2/2/25, a QAPI meeting was held with team members to discuss R1 incident and plan of correction. Plan of correction initiated immediately. On 2/5/25, at 11:04am, the QA team has been notified of the Immediate Jeopardy and the abatement plan has been put into place. QA team will review the results of the audits once a week for 2 weeks then monthly for 2 months to ensure Plan of Correction is effective.