STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146057	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monmouth Rehab and Nursing	117 South I Street Monmouth, IL 61462

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 Note: The nursing home is disputing this citation.	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 adequate supervision and implement interventions for a resident with a known history of elopement and exit-seeking behaviors to prevent elopement and failed to provide adequate supervision for one of one residents (R5) reviewed for elopement risk in the sample of six. These failures resulted in R5 exiting the facility on 1/5/26 without staff knowledge and being found at a local coffee shop two blocks away, near a busy highway, during cold weather conditions when a concerned citizen called 911, and emergency medical services responded.These failures resulted in an Immediate Jeopardy that began on 1/5/26. V1 (Administrator) was notified of the immediate jeopardy on 1/27/26 at 12:10 PM. While the Immediate Jeopardy was removed on 1/28/26, the facility remains out of compliance at a severity level two. Additional time is needed to monitor the effectiveness of the implementation of protocols and quality assurance.Findings include:The facility's Wandering & Elopement Assessment and Prevention policy revised 6/4/2024 documents all residents in this facility shall be assessed for elopement/unsafe wandering, to ensure their safety and prevention from elopement. Elopement is defined as a resident unable to protect themself, who departs the healthcare facility or enters a non-resident area unsupervised or undetected. An incident report will be completed by the Nursing Supervisor noting all investigative procedures, witness statements, and any other pertinent information.R5's census line documents R5 was admitted to the facility on [DATE].R5's Elopement Assessments dated 9/7/23 and 4/3/25 document R5 is at risk for elopement and has previously eloped from the facility. The 4/3/25 assessment also documents R5 exhibits exit-seeking behaviors.R5's Wandering/Elopement assessment dated [DATE] documents R5 has a history of leaving the facility.R5's care plan was updated on 1/6/26 to include wander guard placement, and physician orders dated 1/6/26 document a wander guard was placed on R5. R5's care plan further documents R5 has Alzheimer's/Dementia, Poor Safety Awareness, is at Risk for Falls and R5 walks with a walker and staff supervision.R5's Nurse Progress Note dated 1/7/26 at 11:47 AM documents R5 remains on 15-minute checks for safety and observation after a recent exit-seeking episode.R5's electronic record revealed no Nurse Progress Note or assessment regarding R5 eloping from the facility on 1/5/26.The National Weather Service report for Monmouth, Illinois, dated 1/1/26-1/24/26, documents that on 1/5/26 the outside temperature was a high of 49 F and a low of 28 F.On 1/26/26 at 9:45 AM, R5 was observed lying in bed with the call light attached to the blanket, watching television. R5 was only alert to self during conversation. A walker and manual wheelchair were at the foot of R5's bed.On 1/26/26 at 11:15 AM, V3 (R5's Friend) stated that on 1/5/26, V3 received a call from V1 (Administrator) informing her that R5 had exited the facility, possibly by following visitors out the door unnoticed. V3 stated V1 told her she was very upset and felt terrible that R5 had gotten out, but V1 had found R5 at a local coffee shop. V1 told V3 that R5 stated he had left to help someone fix their car. V3 stated she was notified only after R5 was found, not when he was missing. V3 further (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	stated that shortly after R5 was admitted to the facility in February 2023, R5 had eloped another time because R5 wanted to go to a parade, and nobody would take him. V3 stated R5 was found walking on a busy street and brought back to the facility.On 1/26/26 at 12:05 PM, V2 (Director of Nursing) stated staff and V1 made her aware they were looking for R5 and could not find him. V2 stated she immediately started searching the back hallways and other resident rooms. V2 stated she was told the facility received a call that R5 was found. V2 stated she does not know why there is no documentation in R5's chart regarding the elopement and that it should have been documented in R5's electronic medical record. V2 further stated she assumed the documentation was there.On 1/26/26 at 12:20 PM, V1 (Administrator) stated that on 1/5/26 an unknown Certified Nursing Assistant came to the front office asking if they had seen R5. V1 stated they began searching bathrooms and resident rooms, and when they realized R5 was not in the facility, they searched the perimeter. V1 stated she drove two blocks east, saw EMS (emergency medical services) lights at a local coffee shop, and found R5 there. V1 stated a concerned citizen had called 911 after seeing R5 walking with his walker. V1 stated she was not aware the incident was not documented in R5's chart.On 1/26/26 at 1:45 PM, V8 (Certified Nursing Assistant/CNA) stated R5 got out of the facility, and nobody knew he had left. V8 stated R5 has gotten out before, though V8 was not present during prior incidents. V8 stated R5 can ambulate with a walker or wheelchair depending on the day.On 1/26/26 at 1:48 PM, V6 (CNA) stated she saw R5 walking in the hallway with his walker between approximately 3:50 PM and 4:15 PM. V6 stated after assisting another aide, she was informed staff could not find R5. V6 stated she joined the search and drove with the activity director, locating EMS lights at a local coffee shop where R5 was found.On 1/26/26 at 1:53 PM, V7 (CNA) stated she was told R5 got out of the facility while she was working, but she was not involved in the search because she was assisting another resident.On 1/26/26 at 2:15 PM, V1 (Administrator) stated R5 did not have a wander guard prior to 1/5/26 because R5 refused to wear it, and this refusal was not documented. V1 confirmed R5 previously eloped in September 2023 and was found walking on a street.The facility submitted an abatement plan on 1/27/26 and was advised by the regional office to make revisions before it would be accepted. The facility submitted the revised abatement plan on 1/28/26. Again, the facility was advised to make revisions to the plan. The final abatement plan was submitted on 1/29/26.On 1/29/26 this surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy:1.All staff members present were in-serviced on 1/27/26 and 1/28/26 on the elopement policy and procedure. All remaining staff members will be in-serviced via telephone prior to their next shift by administrator and/or designee.2.On 1/28/26, audit conducted by administrator and director of nurses by auditing medical chart to ensure interventions are in place and documentation of event with all action taken is recorded.3. On 1/28/26 all nurses were in serviced on incident charting and completion by Director of Nursing.4. On 1/27/26 all residents had an updated wandering/elopement assessment completed by Director of Nursing and Assistant Director of Nursing. Care plans were reviewed for accuracy by Director of Nursing on 1/28/26.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to maintain complete and accurate clinical records for two residents (R3, R5) of three reviewed for documentation out of a sample list of six.Findings include:The facility's Charting & Documentation Policy revised 11/5/2019. The purpose of this policy is to maintain a medical record to serve as a legal document that details the services provided to the residents, or any changes in the residents' medical or mental condition, through charting and documentation. Documentation will include information on assessment, notifications, interventions and evaluation including but not limited to: Incidents/ Accidents, Change in Condition, Physician Notification and Responsible party, education provided to resident and or responsible party.1. R5's electronic medical record contained no Nurse Progress Note or assessment regarding R5's elopement from the facility on 1/5/26.R5's care plan was updated on 1/6/26 for wander guard placement, and physician orders dated 1/6/26 documented the wander guard was placed. However, there was no documentation of the elopement event, staff response, or resident condition after returning to the facility.On 1/26/26 at 12:05 PM, V2 (Director of Nursing) stated she assumed documentation was completed but confirmed it was missing from R5's chart.On 1/26/26 at 12:20 PM, V1 (Administrator) stated she was not aware the incident was not documented in R5's chart.2. R3's Medical Diagnosis list documents R3 has Alzheimer's Disease and Dementia.R3's current care plan documents R3 is at risk for Falls and Elopement/Wandering and a wonder guard was placed on R3 on 1/28/26.R3's Nurse Progress Note dated 12/31/25 documents R3 has a bruise under her left eye that is healing. There is no documentation in R3's chart explaining how the bruise occurred, nor any follow-up assessment or investigation.On 1/28/26 at 1:30 PM, V2 (Director of Nursing) stated all incident/accident documentation has been recorded in the facility's internal Risk Management system, which does not carry over into the resident's electronic medical record. V2 stated any assessments related to an incident would not be found in the residents' chart for this reason. V2 further stated she is in-servicing nurses on how to ensure assessments and incident documentation are entered into the resident's medical record.