

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2026
NAME OF PROVIDER OR SUPPLIER Rolling Hills Rehab and Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 68222 Commercial Drive Bridgeport, OH 43912	
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 - Few	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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEYBased on medical record review, interview, and Self-Reported Incident (SRI) review, the facility failed to ensure Resident #200 was free from staff to resident physical abuse when Registered Nurse (RN) #100 inappropriately treated the resident by attempting to spray holy water on the resident. This affected one resident (#200) out of one three residents reviewed for abuse. The facility census was 58.Findings Include:Review of the medical record for the Resident #200 revealed an admission date of 11/12/25 and a discharge date of 03/01/26. Diagnoses included hemiplegia, hemiparesis, aphasia following cerebral infarction, major depressive disorder, anxiety disorder, and a need for assistance with personal care. Review of Resident #200's care plan dated 11/13/25 revealed the resident had a diagnosis of depression. Interventions included education on interventions for triggers and reassurance, non-pharmaceutical interventions included reassurance, diversional activities, decrease stimuli, and allow the resident to vent their feelings. Attentionally the resident had a care plan related to a cerebral vascular incident (CVA/stroke). Interventions included addressing emotional issues.Review of Resident #200's quarterly Minimum Data Set assessment dated [DATE] revealed the resident had moderate cognitive impairment. The assessment also stated the resident had no physical or verbal behaviors.Review of the Self-Reported Incident #271389 dated 02/25/26 revealed the Administrator was made aware that Registered Nurse (RN) #100 asked Resident #200 if she would like her to spray holy water on her to help her feel better. Resident #200 was talking to another resident, and they were using curse words and laughing during their conversation. The nurse sprayed holy water toward Resident #200. Resident #200 didn't agree to this and was visibly bothered by this action. The nurse was suspended pending the investigation. The investigation consisted of witness statements, resident interviews with residents who had a Brief Interview of Mental Status (BIMS) score greater than 12, skin assessments for residents who had a BIMS score less than 12, and retraining of the abuse policy to all staff members. Review of Licensed Practical Nurse (LPN) #150's undated witness statement revealed Resident #200 came to her and reported that someone had sprayed her in the face with something. LPN #150 walked over to the nurse's station and asked RN #100 what happened. RN #100 admitted she sprayed Resident #200 with holy water due to her using the Lord's name in [NAME]. LPN #150 assessed the resident for injuries. Review of RN #100's witness statement dated 02/25/26 revealed on 02/24/26 around 11:00 P.M. two residents were swearing loudly, using an explicit word alongside the name of Jesus. They were reminded to be quieter because it was late. When Resident #200 started to insult the Lord, RN #100 reported to the resident that it hurt her because she was consecrated to the Lord. The resident continued and RN #100 told Resident #200 that she had holy water and that perhaps (the holy water) would help her to be nicer. It was a [NAME] bottle that the nurse had on herself and used on herself often. The nurse then spritzed twice in the direction of the resident from about six feet away. RN #100 reported Resident #200 became very agitated and whipped herself into an emotional state. She was red-faced, pointing, swearing, and continuing to (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	threaten the safety of the nurse. Interview on 04/09/26 at 3:25 P.M. with Regional Director of Clinical Services #153 reported the nurse was terminated related to customer service after the incident. She verified RN #100 did not provide appropriate behavioral intervention related to the incident with Resident #200. The deficiency was corrected on 02/25/26 after the facility implemented the following corrective actions: -On 02/24/26, Resident #200 was assessed for injuries and no injuries were noted. The Medical Director was made aware and an investigation was initiated. -On 02/24/26 RN #100 was removed from the facility and was terminated on 02/25/26 due to poor customer service related to this incident. -On 02/25/26 all residents with a BIMS of 12 or higher were interviewed by the nursing delegates to ensure no further abuse concerns. -On 02/25/26 all residents with a BIMS lower than 12 received skin assessments by the nursing delegates. -On 02/25/26 staff members who were working on 02/24/26 were interviewed by the Administrator regarding the incident with RN #100 and Resident #200. There was one witness identified as LPN #150. -On 02/25/26 the Administrator conducted abuse training for all staff members. -On 02/25/26 the Administrator/designee continued to complete already implemented ongoing guardian angel/adopt a resident monitoring (a program where a nurse manager goes in daily and visits with residents about care needs and if they feel abuse, neglected, and respected) with residents Monday through Friday. The rounds continued daily with Resident #200 until her date of discharge on [DATE]. The results of the audits would be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. -On 02/26/26 an ad hoc QAPI meeting was held with department leadership to discuss the incident, the education that was conducted, and how imposing ones religious beliefs could be considered allegations of abuse or violations of residents rights.		

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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 observation, interview, review of hospital notes, review of consents, and medical record review, the facility failed to implement appropriate interventions and supervision to ensure Resident #2 did not leave the facility without supervision and engage in unsafe behaviors. This affected one resident (#2) out of three residents reviewed for safety interventions. The facility's census was 58. Findings Include: Review of Resident #2's Substance Use Disorder Program consent dated 03/11/26 completed prior to admission to the facility, revealed the objective was to initiate a quality of care program designed to standardize substance use disorder care throughout the facilities for improved outcomes, provide education to the residents affected and staff for continuity of care, decrease potential relapse of Substance Use Disorder and Infection resolution, and provide safety measures for the residents and reduce liability for the facilities. The insight into compliance and effectiveness of the program will be obtained by: Monitoring compliance with PICC line tampering and assessment by the nursing staff if implemented, monitoring mandatory counseling sessions, monitor urine drug screens as needed for compliance with the program, monitor rate of discharge for non-compliance with the Stepping Stones and substance use disorder program, random room searches, random drug screens, and automatic discharge from facility if not following rules: All visitations must occur between the hours of 9:00 A.M. and 5:00 P.M.; All visits will be supervised; Random search of any delivered packages; And no leave of absence (LOA) unless agreed in collaboration with Stepping Stones Counselor, Interdisciplinary Team (IDT), and Physician on a case-by-case basis. Review of Resident #2's hospital discharge paperwork dated 03/23/26 completed prior to admission to the facility, revealed the resident tested positive for amphetamines and cannabinoids. The resident presented to the hospital with bilateral lower extremity pain. He was found to have osteomyelitis of his right third toe and left second toe. He underwent amputation of both toes. He was placed on intravenous (IV) antibiotics and discharged with a peripherally inserted central catheter (PICC) line. Review of the medical record for Resident #2 revealed a facility admission date of 3/24/26. Diagnoses included bipolar disorder, alcohol abuse, anxiety disorder, other psychoactive substance abuse disorder, atrial fibrillation, and acquired absence of the left toe. The resident was his own responsible party. Review of Resident #2's elopement assessment dated [DATE] revealed he was at a low risk. Review of Resident #2's care plan dated 03/25/26 revealed the resident had a substance abuse disorder. Interventions included that residents would attend all group and individual stepping stone activities during stay, will complete all homework group and individual assignments, and will follow the Stepping Stones protocol. Review of Resident #2's skin assessment dated [DATE] revealed the resident a surgical wound to his right foot measuring 2.3 centimeters (cm) length, by 0.1 cm width, and 0.1 cm depth. Review of Resident #2's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) of 15 indicating his cognition was intact. Review of Resident #2's Functional Abilities and Goal assessment dated [DATE] revealed the residents' lower extremities had an impairment on both sides and he utilized a wheelchair or scooter. Review of the LOA sign out sheet revealed Resident #2 signed out at 04/02/26 at 3:38 P.M. and back in at 9:40 P.M. Review of the nursing progress note dated 04/02/26 at 2:00 P.M. but created on 04/03/26 at 1:21 P.M. by Assistant Director of Nursing (ADON) #157 revealed she was informed by staff the resident had signed himself out. There was confusion as to if he was picking up Chinese food, getting belongings, etc., Staff were asked where he was going, and they were told to notify her (ADON #157) upon his return, and to notify the medical director. The resident had a BIMS of 15, and the LOA book was observed at this time and the resident had signed himself out. Review of the facility investigation revealed on 04/02/26, Resident #2 discussed with staff throughout the day he was going LOA but did not give a time. Around 4:00 P.M., the resident left LOA to get his personal (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	items via a friend's car. At 5:08 P.M., the local police department called and reported someone escaped from the facility. Staff reported Resident #2 was noted to be on LOA to get items. Police asked if the resident was safe and the facility reported yes, he was his own person, and alert and oriented times three. At 5:30 P.M., Resident #2's friend came into the facility and brought personal items stating that the resident was coming with his [motorized wheel] chair. At 7:27 P.M., the facility received a text from Licensed Practical Nurse (LPN) #156 stating Resident #2 was on the sidewalk in the community wearing a hat, boots, black shorts, a grey shirt and a hospital gown. At 8:00 P.M., the resident called the facility stating that he was at a local tavern charging his [wheel] chair. At 9:32 P.M., the facility was notified that the resident was in the parking lot heading into the facility and the provider was made aware. At 9:47 P.M., staff noted Resident #2 signed back into the facility. A skin sweep and head to toe assessment was completed without abnormal findings. Observation and interview on 04/08/26 at 10:30 A.M. of Resident #2 revealed he was wearing a surgical boot to his right foot, had a PICC line to his right arm, his gait was slightly unsteady, and he had a large, motorized wheelchair in his room. Resident #2 revealed his sister picked him up on 04/02/26 to pick up his motorized wheelchair. He reported he signed out LOA but did not report to staff he was leaving. He reported he knew he was not supposed to leave unsupervised due to conversations he had previously with administration but due to the opportunity to get his chair he decided to leave anyway. He stated once he got to the apartment where his chair was at, he had to ride it back to the facility. He stated he talked to the facility and told them what was going on and asked to be picked up. They reported to him that they were not going to pick him up. He stated he had to stop at several locations on the way home to charge his chair. He stated it was approximately five miles he had to travel. He stated he also pushed the chair part of the way home. He reported when he got back, they gave him his medication and assessed him for injury. Interview on 04/08/26 at 2:21 P.M. with Certified Nursing Assistant (CNA) #151 reported she was Resident #2's CNA on 04/02/26. She was aware he planned to leave to get his wheelchair, but was not sure of a time. She did not believe he had privileges to leave and he did not report to her when he left the facility. She reported that LPN #156 was aware that he was planning to leave. Interview on 04/08/26 at 3:08 P.M., admission Director #152 stated Resident #2 tested positive for amphetamines during his prior hospitalization (before facility admission) and was admitted on the Stepping Stones program, and he had to sign the Stepping Stones consent to be admitted to the facility. They were in between counselors so there were not any meetings going on. She had talked to him, and he was aware he was not allowed to leave the facility without supervision. She went on to say he did not report to anyone before he left, but once they were aware he had left, she was able to communicate with him via his cell phone. He had expressed concerns about needing his motorized wheelchair since his admission but no one at the facility had gotten it for him and no one had dropped it off for him. She reported the Administrator told him that if he could find a way, then he could get it, so his sister and a friend came in and picked him up. admission Director #152 reported to the Administrator after he left asking if we [indicating the facility staff] could pick him up with his chair so he wouldn't be riding it back to the facility, but the Administrator stated she was not going to. admission Director #152 reported he had to ride it back on the highway and stopped at a random person's house, a fast-food restaurant, and a tavern to charge his chair. He arrived back at 9:30 P.M. Interview on 04/08/28 at 3:40 P.M., the Administrator stated facility staff made her aware that Resident #2 had left without reporting to anyone but did sign the LOA book. She confirmed was aware he was riding his wheelchair back but did not offer to pick him up, stating by the time she made it to the facility he would already be making his way back. She went on to say that the facility no longer offered the Stepping Stones program, so he did not have any restrictions in place. Interview on 04/08/26 3:50 P.M., Regional Director of Clinical Services #153 reported Resident #2 was recently admitted with the intention to be on the Substance Abuse Disorder Program [Stepping Stones] but since they did not have a counselor available, he was never actually placed on the program. She reported the facility did not assess his needs for additional supervision or (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	add interventions due to his high cognition. She verified at this time his care plan stated he was to follow the Stepping Stones protocol and he did sign the consent for the safety interventions. She stated once he returned, he was educated on safety precautions and needed to report to someone if he was leaving the facility. Interview on 04/08/26 at 4:20 P.M. with Physician #155 reported that if Resident #2 was leaving without supervision he would have preferred for him to sign out Against Medical Advice (AMA) due to the risk related to having a PICC line. Interview on 04/09/26 at 1:23 P.M., LPN #156 reported he was Residents #2's nurse on 04/02/26. He stated the resident didn't specifically come to him and report he was leaving. He had previously been talking about having a power chair since his admission and how if he didn't get it, someone else would sell it. He was really focused on this power chair and the day he left he was mentioning the power chair a little more than usual. He overheard a conversation where the resident was trying to pinpoint where it was. He was pretty sure the resident was going to leave that day. LPN #156 stated he was not sure how the resident got the LOA book to sign out, but thinks that he must have gone behind the desk to get it himself. LPN #156 reported he was told the resident was on the Stepping Stones program and had limited access to LOAs. He reported once he realized Resident #2 signed out LOA, he let Assistant Director of Nursing (ADON) #157 know around 4:00 P.M. and LPN #156 reported when he left the facility, Resident #2's picture was already on social media, and he was able to pass him on the way home. He stated he had regular clothing on and a hospital gown over his clothing. He reported he sent a picture to the ADON. Interview on 04/09/26 at 2:50 P.M., ADON/Wound Nurse #157 reported around 3:30 P.M. Resident #2 left the facility by signing out but did not verbally tell anyone. She advised staff to call the Physician upon his return to the facility. She went on to say the local police department called and asked if he was safe. She reported that he signed himself out LOA, had a BIMS of 15, and was alert and oriented. At 6:15 P.M., the resident's sister called and reported the resident was riding his chair back to the facility. She stated she did not offer to provide transportation back to the facility and stated he arrived back around 9:30 P.M. and he received a skin assessment and drug test which he passed. This deficiency represents an example of continued non-compliance investigated under Complaint Number 2973326.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of hospital paperwork, review of Substance Use Disorder Program consent, review of the facility investigation, and record review, the facility failed to ensure residents received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for substances abuse. This affected one resident (#2) out of three residents reviewed for safety interventions. The facility's census was 58. Findings Include: Review of Resident #2's Substance Use Disorder Program consent dated 03/11/26 completed prior to admission to the facility, revealed the objective was to initiate a quality of care program designed to standardize substance use disorder care throughout the facilities for improved outcomes, provide education to the residents affected and staff for continuity of care, decrease potential relapse of Substance Use Disorder and Infection resolution, and provide safety measures for the residents and reduce liability for the facilities. The insight into compliance and effectiveness of the program will be obtained by: Monitoring compliance with PICC line tampering and assessment by the nursing staff if implemented, monitoring mandatory counseling sessions, monitor urine drug screens as needed for compliance with the program, monitor rate of discharge for non-compliance with the Stepping Stones and substance use disorder program, random room searches, random drug screens, and automatic discharge from facility if not following rules: All visitations must occur between the hours of 9:00 A.M. and 5:00 P.M.; All visits will be supervised; Random search of any delivered packages; And no leave of absence (LOA) unless agreed in collaboration with Stepping Stones Counselor, Interdisciplinary Team (IDT), and Physician on a case-by-case basis. Review of Resident #2's hospital discharge paperwork dated 03/23/26 completed prior to admission to the facility, revealed the resident tested positive for amphetamines and cannabinoids. The resident presented to the hospital with bilateral lower extremity pain. He was found to have osteomyelitis of his right third toe and left second toe. He underwent amputation of both toes. He was placed on intravenous (IV) antibiotics and discharged with a peripherally inserted central catheter (PICC) line. Review of the medical record for Resident #2 revealed a facility admission date of 3/24/26. Diagnoses included bipolar disorder, alcohol abuse, anxiety disorder, other psychoactive substance abuse disorder, atrial fibrillation, and acquired absence of the left toe. The resident was his own responsible party. Review of Resident #2's admission Minimum Data Set 3.0 assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) of 15 indicating his cognition was intact. Review of Resident #2's care plan dated 03/25/26 revealed the resident had a substance abuse disorder. Interventions included that residents would attend all group and individual stepping stone activities during stay, will complete all homework group and individual assignments, and will follow the Stepping Stones protocol. Review of the medical record revealed no documented evidence that Resident #2 was receiving Stepping Stones activities, assignments, homework, or follow ups with a counselor. Review of the LOA sign out sheet revealed Resident #2 signed out at 04/02/26 at 3:38 P.M. and back in at 9:40 P.M. Review of the nursing progress note dated 04/02/26 at 2:00 P.M. but created on 04/03/26 at 1:21 P.M. by Assistant Director of Nursing (ADON) #157 revealed she was informed by staff the resident had signed himself out. There was confusion as to if he was picking up Chinese food, getting belongings, etc., Staff were asked where he was going, and they were told to notify her (ADON #157) upon his return, and to notify the medical director. The resident had a BIMS of 15, and the LOA book was observed at this time and the resident had signed himself out. Review of the facility investigation revealed on 04/02/26, Resident #2 discussed with staff throughout the day he was going LOA but did not give a time. Around 4:00 P.M., the resident left LOA to get his personal items via a friend's car. At 5:08 P.M., the local police department called and reported someone escaped from the facility. Staff (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported Resident #2 was noted to be on LOA to get items. Police asked if the resident was safe and the facility reported yes, he was his own person, and alert and oriented times three. At 5:30 P.M., Resident #2's friend came into the facility and brought personal items stating that the resident was coming with his [motorized wheel] chair. At 7:27 P.M., the facility received a text from Licensed Practical Nurse (LPN) #156 stating Resident #2 was on the sidewalk in the community wearing a hat, boots, black shorts, a grey shirt and a hospital gown. At 8:00 P.M., the resident called the facility stating that he was at a local tavern charging his [wheel] chair. At 9:32 P.M., the facility was notified that the resident was in the parking lot heading into the facility and the provider was made aware. At 9:47 P.M., staff noted Resident #2 signed back into the facility. A skin sweep and head to toe assessment was completed without abnormal findings. Interview on 04/08/26 at 2:21 P.M. with Certified Nursing Assistant (CNA) #151 reported she was Resident #2's CNA on 04/02/26. She was aware he planned to leave to get his wheelchair, but was not sure of a time. She did not believe he had privileges to leave and he did not report to her when he left the facility. She reported that LPN #156 was aware that he was planning to leave. Interview on 04/08/26 at 3:08 P.M., admission Director #152 stated Resident #2 tested positive for amphetamines during his prior hospitalization (before facility admission) and was admitted on the Stepping Stones program, and he had to sign the Stepping Stones consent to be admitted to the facility. They were in between counselors so there were not any meetings going on. She had talked to him, and he was aware he was not allowed to leave the facility without supervision. She went on to say he did not report to anyone before he left, but once they were aware he had left, she was able to communicate with him via his cell phone. He had expressed concerns about needing his motorized wheelchair since his admission but no one at the facility had gotten it for him and no one had dropped it off for him. She reported the Administrator told him that if he could find a way, then he could get it, so his sister and a friend came in and picked him up. admission Director #152 reported to the Administrator after he left asking if we [indicating the facility staff] could pick him up with his chair so he wouldn't be riding it back to the facility, but the Administrator stated she was not going to. admission Director #152 reported he had to ride it back on the highway and stopped at a random person's house, a fast-food restaurant, and a tavern to charge his chair. He arrived back at 9:30 P.M. Interview on 04/08/28 at 3:40 P.M., the Administrator stated the facility no longer offered the Stepping Stones program so he did not have any restrictions in place. Interview on 04/08/26 3:50 P.M., Regional Director of Clinical Services #153 reported Resident #2 was recently admitted with the intention to be on the Substance Abuse Disorder Program [Stepping Stones] but since they did not have a counselor available, he was never actually placed on the program. She reported the facility did not assess his needs for additional supervision or add interventions due to his high cognition. She verified at this time his care plan stated he was to follow the Stepping Stones protocol and he did sign the consent for the safety interventions. She stated once he returned, he was educated on safety precautions and needed to report to someone if he was leaving the facility. Interview on 04/08/26 at 4:10 P.M., Social Service Director #154 reported the facility was offering a Substance Abuse Program that they did not actually have. She reported the facility had not had a counselor in several months. She reported she had been at the facility since September 2025 and they had never had a therapist and no one was doing weekly check ins on the residents who were in the program. Interview on 04/08/26 at 4:20 P.M. with Physician #155 reported he was made aware the facility did not have a substance abuse program on 04/07/26. Interview on 04/08/26 at 10:30 A.M. with Resident #2 revealed he was admitted on a Substance Abuse Program and knew he wasn't allowed to leave the facility. He reported and confirmed that he had not received any services related to the program yet. Interview on 04/09/26 at 1:23 P.M., LPN #156 reported he was Residents #2's nurse on 04/02/26. He stated the resident didn't specifically come to him and report he was leaving. He had previously been talking about having a power chair since his admission and how if he didn't get it, someone else would sell it. He was really focused on this power chair and the day he left he was mentioning the power chair a little more than usual. He overheard a (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conversation where the resident was trying to pinpoint where it was. He was pretty sure the resident was going to leave that day. LPN #156 stated he was not sure how the resident got the LOA book to sign out, but thinks that he must have gone behind the desk to get it himself. LPN #156 reported he was told the resident was on the Stepping Stones program and had limited access to LOAs. He reported once he realized Resident #2 signed out LOA, he let Assistant Director of Nursing (ADON) #157 know around 4:00 P.M. and LPN #156 reported when he left the facility, Resident #2's picture was already on social media, and he was able to pass him on the way home. He stated he had regular clothing on and a hospital gown over his clothing. He reported he sent a picture to the ADON. Observation on 04/09/26 at 1:35 P.M. of Residents #2 revealed he was upset, unable to keep his head up, and smelled of alcohol. Interview on 04/09/26 at 1:40 P.M., Regional Director of Clinical Services #153 reported Residents #2 went to appointment earlier today where he received bad news. Once he returned, he decided to leave for the store. He did not sign out or tell anyone he was leaving. Interview on 04/09/26 at 2:33 P.M., Transporter #158 reported they arrived back at the facility around 12:00 P.M. today. The resident stated he did not want to come back to the facility. She told the resident to talk to the nurse and see if he could sign himself out. She reported he followed her into the facility, and she assumed he went to talk to the nurse. Interview on 04/09/26 at 3:00 P.M. Activity Director #159 heard that Resident #2 was at a local grocery store. She drove to the store to speak with him. Once she arrived, she noticed the resident had a bottle of alcohol. He willingly gave her the bottle, and she noticed some had spilled on him. She was able to convince him to come back to the facility. She is unsure of how much he drank, or if any. Interview on 04/09/26 at 3:25 P.M., Regional Director of Clinical Services #153 reported Resident #2 left the facility today after his doctor's appointment without notifying staff. He was found at the local grocery store with alcohol. He was transported back to the facility where he wanted to sign out Against Medical Advice (AMA) and then made comments about self-harm. He then was pink slipped to the emergency room. Regional Director of Clinical Services #153 confirmed there were no policies, procedures, or admission information for the Stepping Stones program other than the consent form.		