STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365559	a. building _____ b. wing _____	04/13/2026

name of provider or supplier	street address, city, state, zip code
ROLLING HILLS REHAB AND CARE CTR	68222 COMMERCIAL DRIVE BRIDGEPORT OH, 43912

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F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER 22959775 COMPLAINT NUMBER 2969836 COMPLAINT NUMBER 2973326 ADMINISTRATOR: Tiera Woolmaker, #7394 CERTIFIED BED CAPACITY: 75 CENSUS IN HOUSE: 58 The following deficiencies are based on the complaint investigation completed on 04/13/26. The facility remains out of compliance from the survey dated 03/11/26.	F 0000		
F 0600 SS=D	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 0600	Past noncompliance: no plan of correction required.	

laboratory director's or provider/supplier representative's signature	title	(x6) date
	JOHN.HARTSOUK	04/27/2026

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F 0600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This STANDARD is not met as evidenced by: THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY Based 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	F 0600		

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F 0600	Continued From page 2 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-pharmacal 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 02/19/26 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	F 0600		

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F 0600	Continued From page 3 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 vain. 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 spritzer 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	F 0600		

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F 0600	Continued From page 4 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 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.	F 0600		

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F 0600	Continued From page 5 -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 03/01/26. 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.	F 0600		

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F 0689	Continued From page 6	F 0689		
F 0689 SS=D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This STANDARD is not met as evidenced by: 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	F 0689	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truths of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirements under the state and federal law. This plan of correction will serve as the Facility's allegation of substantial compliance and completion with an allegation of compliance date of 4/28/2026 Resident #2 no longer resides in the facility. On 4/23/2026 the Director of nursing/designee identified and interviewed all like residents with a BIMS 13 and higher to address any needs expressed of belongings needed outside of facility. No one identified any needs outside of facility. Director of Nursing/designee will educate all staff that if the any resident has any needs outside of the facility to fill out a concern form and give concern form to Social Service or Administrator to be addressed. This will be completed by 4/28/2026. Director of Nursing/designee will educate all staff to include LOAs, and will be completed by 4/28/2026. Residents requiring supervision for LOAs were reviewed on 4/23/2026 by Director of Nursing to ensure they are receiving appropriate supervision when needed. To ensure the deficient does not recur the Director of Nursing/designee will audit any new admissions for assistance with outside needs x 4 Weeks then continue compliance with daily room checks done by all department managers daily Monday thru Friday.	04/28/2026

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F 0689	Continued From page 7 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	F 0689		

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F 0689	Continued From page 8 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 03/24/26 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 03/30/26 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.	F 0689		

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F 0689	Continued From page 9 Review of Resident #2's admission Minimum Data Set 3.0 assessment dated 03/31/26 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 03/31/26 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.	F 0689		

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F 0689	Continued From page 10 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 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	F 0689		

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F 0689	Continued From page 11 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	F 0689		

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F 0689	Continued From page 12 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	F 0689		

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F 0689	Continued From page 13 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 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	F 0689		

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F 0689	Continued From page 14	F 0689		

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

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F 0689	Continued From page 15 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.	F 0689		

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F 0740	Continued From page 16	F 0740		
F 0740 SS=D	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide 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. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This STANDARD is not met as evidenced by: 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:	F 0740	Resident #2 no longer resides at the facility. On 4/23/2026 Director of nursing /designee reviewed program policy and contract to discover any like residents, no qualifying residents for the program as of 4/23/2026. On 4/17/2026 new counselor/therapist started to be available to provide services. As of 4/23/2026 there are currently no residents on the program. To ensure the deficit practice does not recur the Administrator/designee will assess new referrals/admission to the facility if they meet criteria to participate in the substance use disorder program. Regional Director of Operations will educate facility program director and facility administrator on substance use disorder program. This will be completed by 4/27/2026. On 4/23/2026 Administrator/designee will educate all staff on program guidelines and contract. Audits will be completed weekly by the Administrator/designee with any residents on the program to ensure program is being compliant if not compliant, physician notified. Administrator/designee will add any new candidates to the audit upon admission x 4 weeks.	04/28/2026

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F 0740	Continued From page 17 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.	F 0740		

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F 0740	Continued From page 18 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 03/31/26 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	F 0740		

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F 0740	Continued From page 19 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.	F 0740		

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F 0740	Continued From page 20 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 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	F 0740		

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F 0740	Continued From page 21 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.	F 0740		

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F 0740	Continued From page 22 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	F 0740		

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F 0740	Continued From page 23 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 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	F 0740		

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F 0740	Continued From page 24 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 convivence him	F 0740		

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F 0740	Continued From page 25 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.	F 0740		