

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000624		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2026	
NAME OF PROVIDER OR SUPPLIER MONMOUTH REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 117 SOUTH I STREET , MONMOUTH, Illinois, 61462			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			02/13/2026	
	Complaint Investigation 2620532/2715681						
S9999	Final Observations		S9999			02/13/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210d)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section						

Office of Primary Care and Health Systems Management

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

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000624		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2026	
NAME OF PROVIDER OR SUPPLIER MONMOUTH REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 117 SOUTH I STREET , MONMOUTH, Illinois, 61462			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S9999	Continued from page 1 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: 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. 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 themselves, 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 2/14/23. R5's Elopement Assessments dated 9/7/23 and 4/3/25 document R5 is at risk for elopement and has previously		S9999				

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000624		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2026	
NAME OF PROVIDER OR SUPPLIER MONMOUTH REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 117 SOUTH I STREET , MONMOUTH, Illinois, 61462			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 2 eloped from the facility. The 4/3/25 assessment also documents R5 exhibits exit-seeking behaviors. R5's Wandering/Elopement Assessment dated 1/5/26 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 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			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000624		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/29/2026	
NAME OF PROVIDER OR SUPPLIER MONMOUTH REHAB AND NURSING				STREET ADDRESS, CITY, STATE, ZIP CODE 117 SOUTH I STREET , MONMOUTH, Illinois, 61462			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S9999	Continued from page 3 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. (B)			S9999			