STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S 000	Initial Comments Complaint Investigation: 2346821/IL163302	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)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 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	S9999	Attachment A Statement of Licensure Violations	

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care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

This REQUIREMENT is not met as evidenced by:

Based on interview, observation, and record review, the facility failed to provide supervision to prevent elopement for 1 of 5 residents (R1) reviewed for supervision and accident prevention in the sample of 29. This failure resulted R1 exiting the facility and was found on the ground, in a field, near a busy interstate and road. This failure has the potential to affect not only R1, but R4, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, and R25, who have been identified as a high risk for elopement by the facility.

Findings include:

R1's Face Sheet documents, R1 was admitted to the facility on 10/28/2022 with diagnoses, including Unspecified Dementia, Emphysema, Encephalopathy, Dysphagia, (Difficulty

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Swallowing), and Weakness.

R1's Minimum Data Set, (MDS), dated 5/10/2023 documented, R1 was severely cognitively impaired, required extensive assistance with walking, and had no exhibited wandering behavior.

R1's Care Plan, initiated 12/29/2022 documents, "(R1) is at a high risk for elopement." The Care Plan was last updated on 8/20/23, to include the following interventions, "8/20/23 q15, (every 15 minute), checks; Allow concerns to be expressed; Encourage resident to keep busy with activities; Monitor where abouts PRN, (as needed); Redirect resident to activities of choice or SS (Social Services) group." R1's Care Plan also documented R1 was at risk for falls related to dementia.

R1's Elopement Evaluation, dated 5/17/2023, documented, R1 was at high risk of elopement. R1's next Elopement Evaluation was prior to his elopement on 8/6/2023 and documented, R1 was at low risk of elopement. R1's Elopement Evaluation following his elopement on 8/11/2023 documented, R1 was again at high risk of elopement.

R1's Progress Note by V28 (Licensed Practical Nurse/LPN), on 6/19/23 at 7:25 AM documents, "Resident awoke (woke), up and walked the hall and urinated in the hallway. Resident easily redirected and care provided."

R1's Progress Note by V28 (LPN) on 6/25/23 at 6:01 AM documents, "Resident up at nursing station most of night shift. Easily redirect able. Wonders (Wanders) unit."

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S9999	Continued From page 3 R1's Progress Note by V28 (LPN) on 7/8/23 at 12:18 AM documents, "Resident awake, closely monitored, due to wondering (wandering) behavior." R1's Progress Note by V28 (LPN) on 8/11/2023 at 7:15 AM documents, "CNA (Certified Nursing Aide) approached writer at 0345 (3:45 AM), stating that (R1) was not in his room and asked where he was. (R1) unable to express event (sic). Immediately, writer went to room and (R1) not in bed. Asked CNA assigned to (R1) and stated that when she came in at before 10:00 pm shift she asked nurse where (R1) was and stated, that the previous nurse stated, that (R1) went to hospital. Writer immediately went into nurses notes and noted that there were no notes indicated (indicating) (R1) went to hospital. Writer initiated a search of the complete facility including shower rooms and bathrooms. (R1) unfounded (not found) at that time. Writer and fellow nurse did complete perimeter search. Ensuring all doors were alarmed and (R1) not in closed patio areas. Call placed to (V2) DON (Director of Nursing). (V2) instructed to call 911 and that she would notify (V1) Administrator and would call writer back. In the meantime, fellow staff drove around 1 mile radius of facility including church parking lots, surrounding field and ditches on sides of the roads at 0500 (5:00 AM), (R1) noted on the grounds (sic) when completing another search. RN (Registered Nurse), DON, along with Administrative Staff assessed resident prior to (R1) getting off the ground. (R1) noted to be laying (lying) on right side in grass. ROM (Range of Motion) attempted, resident had difficulty with movement to right arm and right leg. (R1) base line is alert and orientated (oriented) to self, able to make needs known at times. (R1) hard to direct with	S9999		

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ROM. Due to that fact, (R1) then assisted to a wheelchair and back in the building before further evaluation."

R1's Emergency Department Note from (Local Hospital) dated 8/11/23 at 7:19 AM documents, "this 70-year-old male who arrives via EMS (Emergency Medical Services) from (Facility). Apparently, this patient was found outside of the (Facility), and the confusion arises now how long he was outside. One story states 2 days and the other source states 1 hour." "General appearance: cooperative, comfortable, frail appearing and appears older than stated age." "Other: there are minor nontender abrasions over both shoulders anteriorly (on front side)." "This patient's mental and physical status has remained unchanged while in department. CT (Computed Tomography) of the neck and head are unremarkable. Patient to be discharged back to (Facility)."

R1's Progress Notes by V36 (LPN) on 8/11/2023 at 12:10 PM documents, "(R1) returned from (Local Hospital). NNO (No New Orders) were received from hospital visit. All labs were WNL (Within Normal Limits). (R1) CT and xrays (X-rays), were negative and did not have any fractures present. (R1) is now resting in his bed at this time."

The Facility's Incident Timeline dated 8/11/23 documents:
"4:00 am (V2) DON received call from (V28) Charge Nurse to inform they could not locate resident (R1). 4:06 am received call from (V2) DON informing me of resident (R1) not located in facility. (V2) informed to contact Police for assistance. (V1) informed by (V2) this time, that charge nurse contacting hospitals. (V28) stated,

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she had directed staff to do complete head count in facility and search for resident. (V28) directed staff outside facility to search for resident. Guardian notified.

4:08 am (V1) Administrator began notifying managers of situation and requesting to assistance.
4:10 am (V35) NP (Nurse Practitioner) notified of not being able to locate.
4:15 am Police arrived at facility, police received information including picture of resident, distinguishing markings, demographics. Police assist with search. (V2) DON initiated staff interviews.
4:30 am search continues involving the immediate area outside facility and surrounding areas.
5:00 am Resident located lying on ground in adjacent grassy area, nursing assessment completed. Resident assisted to WC (wheelchair) to transport back in facility and further nursing assessment. Resident transferred to Hospital as precautionary. Police, Physician and Guardian notified. Staff remained 1:1(one on one supervision), with res(resident), until EMS (Emergency Medical Services), arrived.
12:10 pm Ret'd (Returned) from ER (Emergency Room). No sig (significant injuries), 1:1 continued, Elopement Assessments for all res reviewed along with CP (Care Plan), updates as needed. Elopement Binders reviewed et (and) updated as needed. Res returned to facility 1:1 continued."

On 8/24/23 at 11:56 AM, V13 (CNA) stated, she arrived at work around 9:45 PM on 8/10/22 and was doing a walk through to check on her residents, when V31 (Agency Nurse) told her R1 was in the hospital. Later in the shift, V30

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(Unknown Employee) came to V13 and asked where R1 was located. V30 stated, R1 had a doctor's appointment earlier in the day, but came back to the facility afterwards. V13 stated, she went back to check with V31 (Agency Nurse), and they discovered R1 was missing. He was found at a church by the facility. V13 was helping search for him. Staff looked all through the facility and someone else finally found him outside behind the laundry area and by the church. When V13 went outside, R1 was lying on the ground and had right eye swelling. She stated, R1's tongue was sticking out of his mouth and swollen. He was on the ground and complained about his leg, but they moved him to a wheelchair. V13 stated it was light outside when they found R1 and estimates finding him at 4-5:00 AM but was unsure exactly how long they were looking for him. V13 stated, when she got to the door to go outside to check on R1 there were no alarms going off, and she assumed they had already been turned off. She stated, "(R1) wasn't able to tell me what happened. I think he has dementia and is always pretty confused."

On 8/24/2023 at 12:00 PM V1 (Administrator) stated, the CNA on night shift thought R1 was out of the facility for a visit. She stated the last time R1 was seen on 8/10/23 was at 10:30 PM and was later found in a grassy area near the facility by staff.

On 8/24/2023 at 12:45 PM V15 (Dietary Aide) stated he has seen R1 trying to get out of the facility.

On 8/24/23 at 1:14 PM, V16 (Laundry Aide) stated R1 wanders throughout the building and often stands by the doors and watches the cats outside.

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S9999	Continued From page 7 On 8/24/23 at 1:20 PM, V11 (CNA) stated, R1 has tried to get out of the facility before and can be combative at times. She stated someone must have shut off the alarm without checking to see if anyone was outside. On 8/24/23 at 1:58 PM, V22 (Ombudsman) stated she was not made aware of R1's elopement, but sometimes during the day they let residents on the independent side of the building go outside, and the door at the end of the "Women's Hall" is left unlocked. She stated, she has seen residents trying to get out of the building. On 8/24/23 at 2:18 PM, V21 (CNA) stated she remembers R1 being anxious that day and trying to get out of the facility. On 8/24/23 at 3:17 PM, V23 (CNA) stated R1 wanders around the facility and pushes on the doors. On 8/24/23 at 3:25 PM, V25 (CNA) stated R1 wanders the halls all the time and shakes the door handles. On 8/24/23 at 3:29 PM, V29 (LPN) stated R1 is very confused. On 8/25/23 at 8:30 AM, V26 (CNA) stated, R1 kept going back and forth to the door and setting off the alarm on 8/10/23. She stated, "everybody watches (R1)" because he is always wandering and needs to be redirected. She reported cleaning R1 up around 8:30-9:00 PM and took a break between 10:15 and 10:30 PM. R1's roommate usually likes to keep his door closed, and when she walked by around 2:30 AM she	S9999		

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noticed R1 wasn't in there. V13 (CNA) stated, she was told he was in the hospital. I checked with the nurse (V28), and she said R1 was not on the list of hospitalized residents. I said, "We've gotta find (R1). He has dementia and likes to walk. We went outside, couldn't find him anywhere. I can't remember who found him, but he was responding and talking. He said, his shoulder hurt. He was lying on his right side and that was the shoulder he complained about." "(R1) had a bruise over his right eye that looked like he had fallen. He was wearing a pair of jeans; that is all I remember. He was also, wearing a diaper; we brought him in and cleaned him up. He had urinated in his diaper. I don't know how he got out. I think someone turned off the alarm and didn't look to see if he was out there."

On 8/25/23 at 9:11 AM, V27 (Business Office Manager) stated, he got a call around 4:45 AM on 8/11/23 from V1. He was here by 5:00 AM and joined the search for R1. He looked at the field in back and it was starting to get light out. He came around a large mound of gravel and saw R1 lying on the ground by the back of the church building. He stated, R1 was just lying there and responded when spoken to. V27 called the nurses, and they assessed R1 and put him in a wheelchair. V27 could not recall whether R1 was wearing shoes but remembers him wearing a white shirt and jeans which were covered in grass. V27 showed surveyors where R1 was found. This was estimated to be about 250 yards from the street on which the facility resides with a speed limit of 35 mph (miles per hour), and 400 yards from Interstate 255 with a speed limit of 65 mph.

On 8/25/2023 at 9:45 AM, V28 (LPN) stated, "I came in 8/10/2023 at 10:45 PM. The nurse,

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(unknown), who gave me report was very flustered. I did not get a detailed report. There were all kinds of room changes and residents wanting my attention at the beginning of my shift. I was working with a seasoned CNA, I don't remember her name, but she was doing rounds and she said everyone was ok. Later in our shift, I'm not sure what time, a CNA asked where (R1) was. V13 said R1 was at the hospital. We saw he wasn't sent to the hospital. We immediately did a full facility check. I drove my car around and shined my lights in the grassy area. I then called the Police and the DON (V2). (R1) was found lying on his right side. We rolled him over on his back and did range of motion. We stood him up and put him in a wheelchair. The Corporate Team was here, and they assessed him. I did not do a full body assessment. R1 had on a shirt and pants. I don't know if he had shoes on or not. He complained of pain all over, but mostly on the right side."

The (Local Police Department) Report dated 8/11/23 at 4:14 AM by V54 (Police Officer) documents, "I, (V54), responded to (Facility) located at (Address) in reference to a missing person report. Upon arrival, I spoke with (V28), who stated, a resident by the name of (R1) had not been seen since approximately 1500hrs, (3:00 PM), on 8/10/2023. (V28) stated, when she arrived at work at 2300hrs (11:00 PM) on 8/10/2023, she was advised by the on-shift CNA (V13), that (R1) had been sent out, however, there was no chart of which hospital he was transported to or what time he left. (V28) stated, (R1) normally walks the halls, however, he has never left the facility. V28 stated, they have a receptionist normally sitting at the desk and advised her (R1) never left facility that they saw. (V28) stated, the company removed the camera

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system, so there was no way of seeing if he left the building. (V28) provided me with a picture of (R1) which was forwarded to my shift, in case they noticed anyone walking in the area matching the description of (R1). I requested to check (R1)'s room, at which time I was escorted to his room, where I noticed his bed was still made, and both of roommates were sleeping. As I exited the room, I spoke with (V13), who stated she came into work at 2200hrs (10:00 PM) and when she checked (R1)'s room, she noticed the bed was made, and asked the nurse she was relieving where (R1) was, and she advised he had been sent out, but nothing further. I asked the facility administrator (V1) if they wanted (R1) entered as missing, and she stated yes. I then requested dispatch enter (R1) as missing and was provided the FOLLOWING LEADS." "A short time later, I was advised by dispatch (Facility) called back, and advised they located (R1) hiding in the grass behind the facility."

V64 (R1's Medical Doctor) was unavailable by phone on 8/24/23 at 3:28 PM, 8/24/23 at 3:40 PM, 8/25/23 at 8:50 AM, and 8/31/23 at 9:06 AM.

On 8/24/23, the facility provided the following information which identified the residents who were at risk for elopement:
-R1's Elopement Evaluation dated 8/11/23 documented R1 was at high risk for elopement.
-R4's Elopement Evaluation dated 8/11/23 documented R4 was at high risk for elopement.
-R8's Elopement Evaluation dated 8/11/23 documented R8 was at high risk for elopement.
-R9's Elopement Evaluation dated 8/11/23 documented R9 was at high risk for elopement.
-R10's Elopement Evaluation dated 8/11/23 documented R10 was at high risk for elopement.
-R11's Elopement Evaluation dated 8/11/23

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documented R11 was at high risk for elopement.
-R12's Elopement Evaluation dated 8/11/23 documented R12 was at high risk for elopement.
-R13's Elopement Evaluation dated 8/11/23 documented R13 was at high risk for elopement.
-R14's Elopement Evaluation dated 8/11/23 documented R14 was at high risk for elopement.
-R15's Elopement Evaluation dated 8/11/23 documented R15 was at high risk for elopement.
-R16's Elopement Evaluation dated 8/11/23 documented R16 was at high risk for elopement.
-R17's Elopement Evaluation dated 8/11/23 documented R17 was at high risk for elopement.
-R18's Elopement Evaluation dated 8/11/23 documented R18 was at high risk for elopement.
-R19's Elopement Evaluation dated 8/11/23 documented R19 was at high risk for elopement.
-R20's Elopement Evaluation dated 8/11/23 documented R20 was at high risk for elopement.
-R21's Elopement Evaluation dated 8/11/23 documented R21 was at high risk for elopement.
-R22's Elopement Evaluation dated 8/11/23 documented R22 was at high risk for elopement.
-R23's Elopement Evaluation dated 8/11/23 documented R23 was at high risk for elopement.
-R25's Elopement Evaluation dated 8/18/23 documented R25 was at high risk for elopement.

The Facility's "Elopement" Policy revised 9/2021 documents, "A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle." "Residents who are at risk to elope are closely supervised to keep them safe in their environment, while allowing them to move freely about the safe environment." ""Residents at risk to elope will be closely monitored." "All facility staff are responsible for responding to a door/elevator alarm immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 12 This response will include visual check of the immediate vicinity surrounding the door/elevator that tripped the alarm, including the stairwells and outside area." The Facility's "Elopement" Policy revised 8/2023 documents, "Elopement is defined as a situation where a resident who cannot recognize normal dangers and hazards outside the facility leaves the facility without staff knowledge." "All residents will be evaluated upon admission, quarterly, and as needed with newly identified wandering or elopement behavior." "The Administrator, DON, Nursing Supervisor, Department Heads, Therapy Department, each Nursing Station, Reception and Beauty Shop, will keep the list." "Facility exit doors are alarmed so that staff can secure the environment and intercede when a resident attempts to leave the facility." "If no identifiable cause for the triggering alarm can be found, the following measures will be taken a. Administration will be notified. b. Account for all residents performing whole house head count. c. other steps may be taken as warranted." "A"	S9999		