STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF ALTON	3523 WICKENHAUSER ALTON, IL 62002

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S 000	Initial Comments Complaint Investigation: 2348906/IL165911	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These Regulations are not met as evidenced by: Based on interview, observation and record review, the facility failed to adequately supervise a resident to prevent an elopement of 1 of 3 residents (R2) reviewed for supervision. This failure resulted in R2 eloping from the facility. R2 was gone from the facility for approximately 14 hours and sustained a fractured right tibia while out of the facility. Findings include:	S9999		

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S9999	Continued From page 2 On 11/3/23 at 2:35 PM, R2 was observed in his room with the privacy curtain pulled all the way around him. R2 stated he left the facility on 10/10/23 at approximately 11:00 PM - 12:00 AM. R2 stated he went out the front door as two people were going out the door. R2 stated he did not know who they were, but he doesn't think they were staff members. R2 stated he told those two people that he was leaving too. R2 stated he signed himself out and went and sat under a tree, never climbed, or got into the tree and as he was sitting down, he heard a pop in his right knee, and it started hurting. R2 stated he did not go anywhere else just to sit under the tree. R2 stated sometime in the afternoon on 10/11/23 the facility staff found him and was watching him but never came to him. R2 stated the ambulance came and took him to the hospital. R2 stated it was raining during the morning on 10/11/23 and the tree was keeping him out of the rain. R2 stated he's not sure how far away from the facility he was. R2's Release of Responsibility for Leave of Absence, documents R2 signed himself out on 10/10 (no year documented) at 7:15 PM and was signed back in by staff on 10/10 (no year documented) at 7:27 PM and 10/11 (no year or time documented). R2's Face Sheet, undated, documents R2 has a diagnosis of Schizophrenia, Adjustment Disorder and Visual Hallucinations. R2's Minimum Data Set (MDS), dated 8/1/23, documents R2 is cognitively intact and is ambulatory. R2's Care Plan, dated 1/3/22, documents R2 is at risk for wandering/elopement, on 5/21/23, resident left hospital emergency room (ER/ED)	S9999		

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S9999	Continued From page 3 without supervision. R2's Community Survival Skills Evaluation, dated 7/17/23, documents R2 is not capable unsupervised outside pass privileges at this time. R2's Elopement Assessment, dated 5/1/23 and 10/11/23, documents R2 is at high risk for elopement. R2's Progress Notes, document the following: 5/1/2023 at 1:41 PM, resident left via facility transportation with paperwork. Transportation will transport resident to Psychiatric Hospital per MD orders for Evaluation & treatment. 5/1/2023 3:58 PM, Call placed to Psychiatric Hospital to follow-up on resident status. Spoke with ER Nurse. Per ER Nurse "resident was not seen by ER for care". ER Nurse transferred my call to the hospital psychiatric Intake Nurse. Per Intake Nurse "Resident has not been admitted and was not evaluated. Resident was last treated for Psychiatric care on March 9th". ADON, (Assistant Director of Nurses), was notified that resident was not at Hospital. Awaiting further instructions. 5/1/2023 21:00 Hospital House Supervisor contacted facility and writer asking about the whereabouts of the resident, that the police had no information on what was going on and asked for writer to give a face sheet to the police, writer contacted the ADON, she stated that the police were notified, a missing person report was put into effect and that they found resident and 911 was picking him up and taking him to the psychiatric hospital. The ADON stated she contacted the hospital and she had given report to the ER nurse in regard to the resident and his	S9999		

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S9999	Continued From page 4 condition, will follow up with hospital on time of arrival and nurse treating. 5/2/2023 04:32 Resident returned to facility via ambulance. Resident educated on call light usage and importance of letting staff know when he needed anything. Resident verbalized agreement. Resident can make needs known, denies pain or complaints. no signs or symptoms/ distress/discomfort noted at this time. Vital Signs within normal limits, enhanced monitoring protocol initiated. Will continue to monitor resident for safety this shift. 10/11/2023 at 12:37 PM, Resident unable to be located while prepping for lunch meal. All staff immediately began facility search for resident. It was noted that resident did sign self out of the facility without alerting staff of LOA, (leave of absence), but did not sign out a time of LOA, only a signature was present. Staff searched for resident off facility premises also and resident was located nearby and noted to be disoriented to self & situation. Resident stated his name was "Not (R2)" and gave a different name. Resident had complaints of knee pain but stated he "did not fall or anything, it just made a pop sound". Ambulance called to transport resident to hospital ER for evaluation & treatment. Resident's State Guardian notified and detailed message left regarding occurrence and status of resident. ER Nurse was given report and face sheet and order summary faxed to ER. DON, (Director of Nurses), & Administrator aware. 10/11/2023 at 6:50 PM, Resident returned to this facility via ambulance. Resident alert & oriented. Resident has a closed fracture of the lateral portion of the right tibial plateau. Immobilizer in place to right leg. Resident provided meal upon	S9999		

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S9999	Continued From page 5 return et consumed 100% of meal. Staff provided enhanced supervision for elopement risk. No complaints of pain noted. R2's Other Event, dated 10/11/23 at 12:34 PM, documents, R2 was not in the dining room for meal. All staff began searching for resident. Resident is alert, confused/forgetful and non-compliant with safety guidance. No witnesses found and resident unable to give description. R2's ER/ED Notes, dated 10/11/23, document the following: 10/11/23 - arrived in ED 10/11/23 at 3:10 PM, He has pain, swelling and redness to the right knee. This started sometime since yesterday. It was reported that he may have fallen out of a tree. The patient denies any known injury. Physical Exam: right knee swelling, effusion, and erythema present. Decreased ROM, (range of motion), tenderness present. X-Ray of the right knee: Mildly comminuted minimally displaced right lateral tibial plateau fracture. Moderate suprapatellar joint effusion, which is likely post traumatic. Patient to ED via EMS, (Emergency Medical Services), with complaints of right knee pain. Patient eloped from facility sometime last night. Patient felt a pop in his knee followed by pain. Patient states he sat under a tree to seek shelter from the rain and has been there until this afternoon when the staff from the facility found him. Patient denies any falls. He has no complaints other than knee pain at this time. Patient has a history of schizophrenia. Nursing Home staff states patient has not been compliant with medications lately. He refused taking his medications this morning. Patient is calm and cooperative with staff at this time. Clinical Impression: Closed fracture of the lateral portion of the right tibial plateau. EMS call log from	S9999		

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S9999	Continued From page 6 ambulance to Hospital: 10/11/23 at 1:29 PM - elopement from Nursing Home. R2's Medication Administration Record, (MAR), dated 10/2023, documents R2 refused his medication on 10/10/23 at 8:00 PM. It was documented, that R2 was not in the building on 10/11/23 at 7:00 AM for his pain assessment or at 9:00 AM to receive his medications. The Facility Investigation, undated, documents R2 was last seen by R9 on 10/10/23 after the 9:00 PM smoke time. Other residents interviewed did not see R2 after the 7:00 PM smoke time. V23, LPN, (Licensed Practical Nurse), /ADON, V5, CNA, (Certified Nurse Assistant), nor V9 Infection Control Nurse, saw R2 on 10/11/23. On 10/30/23 at 12:50 PM, V1, Administrator, stated that R2 was not made an elopement risk until he did not return from LOA. V1 stated staff noticed R2 was not at lunch on 10/11/23. V1 stated the Nurse was concerned and did not remember R2 being on LOA. V1 stated, that R2 did sign out, but did not sign out a time. V1 stated at 12:30 PM the facility staff started a search. V1 stated, the Police were not notified. V1 stated it was not normal for R2 not to be at lunch. V1 stated that R2 was found sitting under a tree in a front yard. V1 stated R2 did not know his name or how got there, so 911 was called. V1 stated that R2 was unable to stand. V1 stated this was the first time to her knowledge that R2 had eloped. V1 stated after R2 returned to the facility from the Hospital, the facility started elopement drills, the leave of absence policy was reviewed, and resident rights were reviewed. V1 stated this was not typical behavior for R2. V1 stated that R2 likes to sit outside and draw and V1 stated R2 is not an exit seeker. V1 stated R2 was placed on	S9999		

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S9999	Continued From page 7 one-on-one supervision and later placed on 15-minutes checks. On 10/30/23 at 12:53 PM, V2, Director of Nurses, (DON), stated lunch time came around and R2 was not in the dining room, which was odd, so they searched the building. V2 stated R2 was found down the street under a tree. V2 stated R2 complained of knee pain and could not stand, so 911 was called from the site, he was taken to the Hospital and diagnosed with a fractured patella. V2 stated R2 had signed himself out but did not put a time down and did not tell anyone. V2 stated according to the nurse, V24, Licensed Practical Nurse, (LPN), R2 took his morning medications and was in the dining room for breakfast. V2 stated R2 is still having periods of confusion. V2 stated R2 was not previously at risk for elopement but has been care planned for elopement and is in the elopement book. On 11/7/23 at 8:40 AM, V1, Administrator, stated staff noticed R2 was not back for lunch around 12:30 PM on 10/11/23. V1 stated staff went looking for R2 and found him down the road under a tree at 12:40 PM. V1 stated R2 was gone 10 minutes. V1 stated R2 was having a Psychotic episode, though his name was R9, and he was talking to raccoons, so they called the ambulance. On 11/7/23 at 9:28 AM, V1, Administrator, stated they did not interview R2 because he was at the hospital. On 11/7/23 at 9:30 AM, V19, CNA, stated she worked night shift on 10/10/23 and did not recall seeing R2 at all during the night. V19 stated they were moving residents around and wasn't sure if he had been moved.	S9999		

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S9999	Continued From page 8 On 11/7/23 at 9:40 AM, V18, LPN, stated, that she worked 7:00 PM - 7:00 AM on 10/10/23 and she doesn't recall when or where she saw R2, but she was told by management, who looked at the cameras, and said she was entering the building around 7 PM as R2 was exiting the building. V18 stated she must have seen him though, because she would not have documented that he refused his medications at 8:00 PM if he hadn't seen him and attempted to give them to him. V18 stated she doesn't recall seeing him during the rest of her shift. V18 stated R2 is independent so she did not check on him during the night. On 11/7/23 at 10:00 AM, V1, Administrator, stated they did an emergency resident council meeting, elopement drills, etc. but we didn't see R2's event as an elopement because he signed himself out. V1 stated V24, LPN, had told them that she saw R2 on 10/11/23 at the beginning of her shift. V1 stated they are not sure when R2 exited the building. V1 stated they have cameras, but he was not seen exiting the building on 10/10/23 or 10/11/23. On 11/7/23 at 10:15 AM, V24, LPN, stated she worked 7:00 AM - 7:00 PM on 10/11/23, she was working three halls and she did not see R2. V24 stated she didn't see him for his 9:00 AM medication administration, so she documented he was out of the facility. V24 stated staff, unsure of whom, told her after he was deemed missing, that R2 was not in the dining room for breakfast that morning and that his tray was sent to his room, when staff went to pick up his tray, it had been untouched, so they took it out of his room. V24 stated they normally serve lunch around 11:00 AM -11:30 AM and she was in the dining room and noticed R2 was not there for lunch. V24	S9999		

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S9999	Continued From page 9 stated she could not find him, so she took her personal car and began looking for him. V24 stated R2 was found down the hill from the facility, under a tree, maybe a mile or less from the facility. V24 stated R2 was confused and was calling himself a different name and told her that he sat under the tree because the raccoons told him to. V24 stated he told her he hurt his knee and couldn't stand up. V24 stated V2, DON, was there and she thinks she (V2) called 911. V24 stated after EMS came and she talked to them, she went back to the facility to finish her medication pass. V24 stated she is not sure how long R2 had been gone from the facility. On 11/7/23 at 10:40 AM, R9 stated he can't remember if he did or didn't see R2 on 10/10/23 or 10/11/23. The Elopement policy, dated 6/2015, documents elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. Resident at risk of eloping will be closely monitored. All residents will be supervised when exiting the building. (A)	S9999		