STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000808	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus Pavilion at Belleville	**727 NORTH 17TH STREET , BELLEVILLE, Illinois, 62226**

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S0000	Initial Comments Complaint Investigation 2547004/IL2575840 2546838/2572558	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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 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.	S9999		08/26/2025

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

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S9999	Continued from page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 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 requirements are not met as evidenced by: Based on interview, observation, and record review, the facility failed to provide supervision to prevent elopement for 1 (R7) of 3 reviewed for elopement in the sample of 13. This failure resulted in R7, a resident with known desire and attempts to leave the facility, eloping from the facility and found 12 miles away approximately 8 hours later by police. The Findings Include: R7's Admission Record, dated 7/28/25, documents R7 was admitted to the facility on 1/23/25 with diagnosis of Schizophrenia, Alcohol Abuse, Cocaine Abuse, Chronic Obstructive Pulmonary Disease (COPD), Seizures, Hypertension (HTN), and Hyperkalemia. R7's Care Plan, dated 5/20/25, documents R7 has diagnosis of Schizophrenia and may display symptoms that include but not limited to being out of touch with reality (delusional or hallucinations), may have disorganized speech or erratic behavior, decrease in activities. R7 is at risk for seizure activity related to diagnosis of seizures. R7 requires assist with daily care needs. R7 is at risk for falls related to Seizure disorder. R7's Care Plan did not address that R7 was an elopement risk. R7's Minimum Data Set (MDS), dated 5/3/25, documents R7 is cognitively intact and required supervision/touching assistance for Activities of Daily Living (ADLs). R7's current and active physician orders included the use of the following medication regimen: Aricept (dementia) Benztropine (involuntary movements),	S9999		

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S9999	Continued from page 2 Losartan (HTN), Mirtazapine (depression), Naproxen, Nifedipine (HTN), Phenytoin (seizures), Risperidone (anxiety), Trazodone (sleep). R7's Nurses Note, dated 7/25/25 at 2:46 PM, documents "EMS (Emergency Medical Service) showed up because resident called 911. Resident met EMS at the front door and advised she wanted to be taken to "The Center" due to her medication not agreeing with her and wanting to visit her son and daughter. Resident educated that if she wants to speak with her son or daughter to let the staff know and we will get in touch with them for her if she is unable to. Resident verbalized understanding. This RN (registered nurse) attempted to contact daughter with no answer, left message." R7's Nurses Note, dated 7/25/25 at 12:00 AM, documents "This writer discovered resident missing from her room at approx. 11:30p during routine beginning of shift rounding. This writer immediately searches her bedroom/ bathroom, surround hallways as well as a common seating area for residents. No signs of resident. At 11:36p Nurse manager on duty (Xxxxxxx) was notified of the missing patient, as well as a call placed to DON (V2) at 11:38p. An elopement procedure was initiated. 11:40p conducted a thorough search of 100/200 hall, including all patients, rooms, bathrooms, common areas, and exits. Other staff members were notified and assisted with the search. Facility-wide search and outside building perimeter search. Resident emergency contact (daughter) informed of the situation. MD (medical doctor) (V21, Physician) notified of patient absence; no new orders given. 12:20a search of the hall and facility continuing. 12:19a Writer placed a call to 911 and officer gave the writer a non-emergency number to contact for (local) PD (police department). 12:20a the writer spoke with badge #54 officer and gave information about the missing resident and connected me to officer that was on duty patrolling. 12:35a officer arrived to the facility to get more information on resident. Face sheet with photo of resident given to officer. 2:23a (local) PD called and notified residents had been entered in missing person data. 2:30a managers are still out driving around the neighborhood in attempts to locate resident. Will cont. to follow up." [SIC] On 7/28/25 at 2:46 PM, V7, Licensed Practical Nurse (LPN), stated she was the night nurse who found R7 missing. V7 stated she came on duty at 11:00 PM and when she was doing her rounds checking on the residents, R7 was missing. V7 stated she did the proper elopement protocol and notified everyone. V7 stated she is unsure what time R7 left because she was gone by the	S9999		

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S9999	Continued from page 3 time she got on duty, there were no alarms going off when she got to work. V7 stated R7 was not exit seeking and she does not recall her walking out the front door. V7 stated just about every resident who leaves the facility must have someone sign them out of the building. V7 stated for days and evenings, there is someone who mans the front desk, but for nights there is no one there but the alarms do go off. R7's Nurses Note, dated 7/26/25 at 6:50 AM, documents "At approx. 6:50a this Nurse received a call from (local) county jail requesting the resident med list. This writer verbally provided Nurse with all current medications. Nurse states the resident is being held due to a warrant for Alton. (Nurse) states (local town) has 5 days to pick up the resident and cannot be released back to the facility until she sees a judge on Monday. Manager on duty (V20) notified. Called the place to daughter to update her." [SIC] R7's Police Report, dated 7/26/25 at 00:21 AM, documents in part that "On 07/26/2025 at approximately 00:21 hours, I, Ofc. (officer) 154, responded to (facility address) (this facility) for a report of a missing person. The caller advised dispatch that as employees were doing "rounds", they noticed that a female resident was missing, and the last time she was seen was around 1900-2000 (7:00 PM to 8:00 PM) hours. I filled out a missing person form and later turned it into dispatch. (R7) was entered into LEADS (Law Enforcement Agencies Data System) as a missing person. I have attached a photograph of (R7's) "face sheet" from the facility, which includes her medical diagnosis and a photograph of her to reference. At approximately 0550 (5:50 AM) hours, (Local County) Deputies located (R7) at the Metrolink (5th/Missouri). (R7) had an active warrant out of (area town) and was taken into custody for the warrant, and she was removed as missing from LEADS." On 7/28/25 at 11:15 AM, V1, Administrator, stated "We had a resident (R7) who had orders that she can leave whenever she wants. (R7) left the facility on her own, was seen by Police walking down the sidewalk and when they checked on her, she had a warrant for her arrest and was taken to the (local town jail) where she had her warrant. Early this morning, the judge released her, and she is walking around (the local town). We have someone driving there now to talk to her and hopefully bring her back to the facility. (R7) is her own responsibility and has the right to leave when she wants." On 7/29/25 at 11:53 AM, V11, Nurse Practitioner (NP),	S9999		

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S9999	Continued from page 4 stated "(R7) was alert and oriented but did have Schizophrenia, Alcohol Abuse, and Cocaine Abuse. I believe there were a couple of issues going on with her. I was told that on Friday afternoon (7/25/25) (R7) called 911 herself, not because she wanted to go to the hospital, she wanted to leave the facility and go into town. When she found out that the ambulance was not going to take her to town, she refused to go with the ambulance, so they did not transport her. Then on Saturday (7/26/25) I got a text message from the DON (Director of Nurses) that stated (R7) eloped from the facility and the police found her and put her in jail. Then it said further review showed that (R7) left AMA (Against Medical Advice). I believe it was around 10:00 PM that she left, and the facility didn't realize she was gone until the night staff came in around 11:00 PM and made their rounds. On the Monday morning meeting at the facility, I was told that the Social Service Director and the Administrator watched the cameras and seen another family member, who knew the code, open the front doors, walk out the door and leave, with R7 exiting right behind that person. From my standpoint, R7 was alert and oriented but had a psychiatric history. She was able to make her own decisions, and she definitely wanted to leave the facility." When asked if R7 had an order to leave the facility whenever she wanted to, V11 stated "There would never be an order for any resident to go outside or leave the facility on their own. There may be a LOA (Leave of Absence) order for a resident to go with a family member, but they must be signed out first. That facility is not that type of facility where a resident would be able to come and go whenever they wanted. So, in my opinion, yes, (R7) eloped from the facility against providers wishes." When asked if R7 was able to take care of herself or was she putting herself in danger by eloping, V11 stated "I don't believe (R7) was at a point where she would be able to care for herself. By eloping, I would consider her a great risk to harm herself. The managers all had a group message going around about (R7) leaving the facility, you may want to try and get that group message, it started with (R7) eloped from the facility." On 7/29/25 at 12:37 PM, V11, NP, called back and stated, "I talked to my Physician, and he told me he believes that incident was an elopement at the time, but then he was told that after further investigation by the facility, they had the resident sign an AMA form." On 7/29/25 at 2:00 PM, V3, RNC, showed this surveyor the security video of when R7 walked out of the facility. The video shows a family member of another	S9999		

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S9999	Continued from page 5 resident, walk out the door at 9:55 PM and within a second or two, R7 was right behind him, and she walked down the sidewalk and away from the facility. On 7/29/25 at 2:19 PM, V12, Human Resource, stated that she got a call on Friday (7/25/25) night from V1, Administrator, stating that she needed to go to the facility and help look for R7 and to look at the camera to see if she left. V12 stated when she looked at the camera, she saw a resident's family member leaving and shortly after, R7 walked out the door. V12 stated apparently the family member had the code to get out the door and they shouldn't have had it. On 7/29/25 at 2:47 PM, V2, DON, stated as far as she knows, only the employees of the facility should have the code to the doors. V2 stated the night R7 left, she was not able to come in to help but all the managers and corporate came in to look for R7. V2 stated she was not aware of R7 exit seeking, however, R7 was put on every 15-minute checks because she was wandering around and they wanted to keep an eye on her. V2 stated the front door is manned up until around 8:00 PM. On 7/29/25 at 3:10 PM, V1, Administrator, stated that they changed the code to the front doors Monday after R7 left. V1 stated only the employees are supposed to have the code to the door and she is unaware of how R11's father got the code. V1 stated they have smart residents living there and most of them will watch people leave and put the code in and will learn the code. On 7/29/25 at 3:30 PM, V13, Receptionist, stated she works the front desk from 8:00 AM until 4:00 PM on Monday through Wednesday, then works 8:00 AM until 8:00 PM on Thursday and Fridays. V13 stated someone else works the desk from 4:00 PM until 8:00 PM on Monday through Wednesday, then 8:00 AM to 8:00 PM on Saturday and Sunday. V13 stated she never gives out the door code and has no idea how family members are getting the code. V13 stated after 8:00 PM, there is no one that mans the door. On 7/29/25 at 3:35 PM, While speaking with V13, a new sign was seen posted on the front doors. This sign documents "Attention Visitors and Staff: For our resident safety, please be aware of our resident's when you enter or leave the building and immediately report any residents observed exiting the building to management or charge nurse at the nursing stations." On 7/30/25 at 3:25 PM, V18, Certified Nursing Assistant (CNA), stated that R7 was always carrying her purse	S9999		

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S9999	Continued from page 6 around, telling people she was going home, and would call her mother frequently telling her she wanted to go home. On 7/29/25 at 9:15 AM, V4, LPN, stated that she worked with R7 and that R7 always had a bag packed and stating she was going home. V4 stated that she never saw R7 go out the doors but would always walk around the facility telling people she was going home. R7's Elopement Evaluation, dated 6/20/25, documents R7 was a Low Risk for Elopement. R7's Enhanced Supervision Monitoring Tool, dated 7/25/25, documents R7 was last seen in the dining room at 9:45 PM. At 10:00 PM, it documents "Looking for Resident". Per "Google Maps" the distance from the facility to the Metrolink 5th/Missouri station is 12 miles. R7's Social Service Update, dated 7/23/25, documents in part that R7 is alert and oriented to person, place, and time, but is not oriented to situation and mental function varies throughout the day. It continues R7 has clinical issues that interferes with her thought process, R7 is prescribed psychotropic medication to address her symptoms and conditions related to mental illness, is required to attend psychosocial support groups, and R7 has made attempts to walk away from this LTC since the last review. It continues the Risk Screen for Elopement 0-9 is a Low Risk =/> 10 is At Risk with R7's score of 21 indicating R7 was at risk for Elopement. An untitled, undated, document provided by V3, documents a timeline for the incident involving R7's elopement. This in part, documents "Per the Nurses Notes: This writer discovered resident missing from her room at approx. 11:30 PM during routine beginning of shift rounding. This writer immediately searched her bedroom/bathroom, surround hallways as well as a common seating area for residents. No signs of resident. At 11:36 PM, Nurse manager on duty (V20, LPN) was notified of the missing patient, as well as a call placed to DON (V2) at 11:38 PM. An Elopement procedure was initiated. At 2:30 AM, managers are still out driving around the neighborhood in attempts to locate the resident. Will continue to follow up." On 7/31/25 at 12:48 PM, V1 stated "Only the high-risk elopement residents will go into the elopement binder." On 7/31/25 at 2:20 PM, V1 stated "You are not seeing	S9999		

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S9999	Continued from page 7 the clarification on At Risk for Elopement because you don't have the correct policy, we updated the policy on 7/28/25 to reflect only the High Risk for Elopement residents." Per investigation, R7 eloped prior to the change in policy. The Facility's "Elopement" Policy, dated 9/2022, documents in part "Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. All residents will be assessed for elopement risk upon admission, with significant change in condition, and quarterly. Any resident identified at risk to elope will be reviewed every 90 days or with significant change in condition. Elopement Risk: 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. 1. Any resident identified as an elopement risk will have pictures available, one kept at the reception desk and the others in a facility-designated area. 2. Any resident identified at risk to elope upon admission will have the Elopement Risk identified and included in the Interim Plan of Care. A comprehensive elopement prevention plan of care will be developed at the first care plan meeting. The plan will be reviewed at least every 90 days or more often if necessary. 3. There will be a Master List of all residents at risk to elope. The Social Service Department or designated staff will update the list as additional residents are determined to be at risk to elope and it will be reviewed weekly. The list will be available at the nurses' stations and reception area. 4. Residents at risk to elope will be closely monitored." This policy which was in use at the time of R7's elopement did not identify Low or High risk, just "At Risk" residents. (A)	S9999		