STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	**3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2547457/2588257	S0000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	**3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 1 assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 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 supervision to prevent elopement for 1 of 5 residents (R5) reviewed for supervision to prevent accidents in a sample of 8. This failure resulted in R5 eloping through the front entrance at 2:38 AM, on 8/13/25, unsupervised and returning to the facility at 3:36 AM after staff found him approximately 1.2 miles from the facility. Findings include: R5's Face Sheet documented he was admitted to the facility on 6/23/25 with diagnosis of, in part, epilepsy, moderate protein-calorie malnutrition, cannabis abuse and schizophrenia. R5's Minimum Data Set (MDS) dated 7/7/25, documented R5 was severely cognitively impaired and required supervision or touching assistance with transfers. R5's MDS continued to document his ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel was not attempted due to medical condition or safety concerns. R5's Care Plan dated 7/7/25, documented he was at risk for elopement with the following interventions put in place for R5 to be 1:1 with staff date initiated:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 2 07/02/2025; encourage R5 to keep busy with activities date initiated: 07/02/2025; give R5 an opportunity to talk about why he wants to leave, remind him that the doctor would need to approve him leaving date Initiated: 07/07/2025; praise R5 when cooperative date initiated: 07/02/2025; when R5 begins to make statements that he want to go home distract with an activity, offer him a drink, based on weather offer to accompany him to patio date initiated: 07/07/2025. R5's Elopement Risk Assessments dated 7/7/25 and 8/14/25 documented he was at high risk. R5's Progress Note dated 7/6/25 at 5:03 PM documented, "Code yellow called this nurse along with other staff exited the facility to retrieve the R5. R5 noted at the end of the with staff following at a safe distance. Staff asked resident multiple times to return to the facility. R5 cont. (continued) to refuse, R5 yelled he would not return and took off walking faster. Local police arrived and was able to talk R5 into returning. R5 was transported back by cop car, and c/o (complaints of) not wanting to stay and being locked in a prison when he has to work. R5 noted to be mentally unstable and very confused. R5 agreed to wait in the dining room but states he will not stay here at the facility. N.P. (Nurse Practitioner) and Admin (administrator) and management made aware." R5's Psychotropic Provider Note dated 7/8/25 at 10:50 AM documented, "70 yo (year old) M (male) with Schizophrenia, restlessness and agitations. Update obtained from R5 and staff. R5 pleasant and cooperative with assessment. Recently admitted after being hospitalized for a witness seizure. Sitting in the common area at time of assessment. R5 is an elopement risk and is disruptive with his behaviors." R5's Progress Note dated 7/24/25 at 10:02 AM documented, "R5 attempted to leave facility at 9:50 am. Staff able to redirect patient away from door. R5 placed on 15-minute face checks at this time." R5's Progress Note dated 8/1/25 at 2:45 AM documented, "R5 has been awake/up most of NOC (night), wanders halls and sits in dining room. Elopement attempt x 2, this nurse able to redirect without difficulty. Frequent monitoring continues." R5's Psychotropic Provider Note dated 8/1/25 at 1:01 PM documented, "70 yo M with restlessness and agitation and unspecified sleep disorder. Update obtained from patient and staff. Patient pleasant and cooperative with assessment with confusion. Noted to be ambulating	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 3 the halls at time of assessment. Speech continues to be intermittently nonsensical. Staff report that patient stays up most nights wandering the facility and attempting to elope. R5's Progress Note dated 8/13/25 at 2:45 AM documented, "R5 in bed at this time. At approx. (approximately) 0300 (3:00 AM) staff hears front door alarm with no staff exiting building and no one seen outside the front doors. Staff begins room checks for resident accountability. CNA (Certified Nursing Assistant) reports that said resident is not accounted for. Administrator notified. Staff splits up and building search repeated and other staff members outside of building to search with no results. 3 different staff members leave facility in cars to search surrounding areas. Police notified by staff member/receptionist. R5 located on local street (street facility is located on) by staff member at approx. (approximately) 0325 (3:25 AM). Resident returns to facility via private vehicle. No injury noted. No distress. R5 states "I just needed my ID, I'm going to local town" Call placed to ambulance for transfer of resident to have eval (evaluation) done. Ambulance arrives at approx 0425 (4:25 AM) with 2 attendants and will be taken to local hospital for eval and tx (treatment)." R5's Ambulance Report dated 8/13/25 at 4:30 AM, documented he was being transferred to a local hospital for a psychiatric evaluation after elopement from the facility approximately one hour prior. R5's Progress Note dated 8/13/25 at 10:16 AM documented, "R5 returned from local hospital with no new orders." On 8/14/25 at 11:53 AM, V3, CNA, stated she is sitting one on one with R5 to make sure he doesn't go outside. R5 was laying with his blanket over his body and head in bed while V3 sat in a chair at the end of his bed. V3 stated she was not sure what happened, and this is the first time she's really had direct care of R5 so she's not familiar with his behaviors or past if he's ever eloped. On 8/14/25 at 11:58 AM, R5 stated he doesn't remember being outside the facility or at the hospital. R5 stated he was hungry and felt messed up after being asked if he was hurt in any way. R5 did not respond to questions at times and continued to lay in bed with his blanket over his head. On 8/14/25 at 12:35 PM, V1, Administrator, stated on the night of the 12th to the 13th (August 2025), she	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 4 saw via video footage, R5 exit the building unsupervised at approximately 2:37 AM through the front door. V1 stated the receptionist working at the time was on a lunch break but somebody really needs to sit up there while she is on break, and she was educated on that after it happened. V1 stated staff called her at about 3:00 AM to let her know R5 had eloped then shortly after that they found him between 3:00 AM and 3:30 AM. V1 stated her staff did a quick head count twice after hearing the front door alarm and found that R5 was not in his room. V1 stated staff reported they had seen R5 in his room about 10 minutes prior to him leaving the facility. V1 stated she is currently investigating the incident of elopement on R5. On 8/14/25 at 1:42 PM, V5, Receptionist, stated she was working the night R5 eloped. V5 stated she was on a lunch break when R5 got out the front entrance and was told by another CNA when she was returning to the facility that a resident had gotten outside so she turned around a left to look for them. V5 stated she saw R5 close to the board of education building, but he didn't recognize her and told her he was going to the gas station. V5 stated she was nervous about trying to get R5 into her car alone, so she called the police and waited with him. V5 stated after 10-12 minutes she called the facility because the police didn't show. V5 stated R5's CNA V6 was a male and agreed to come help get him back to the facility. V5 stated R5 was not injured from what she could tell but he was out of breath when they got back. V5 stated R5's nurse, V7, gave him a soda to drink. V5 stated she had seen R5 try to exit the building multiple times but was able to redirect him. V5 stated R5 had not eloped for her before this. V5 stated the facility is keeping R5 safely supervised now with a CNA 1:1 assigned to him. V5 stated staff do hourly checks to supervise the residents, door alarms alert us and using visual site to keep residents safe from elopement. V5 stated she had concerns about R5 because he was a flight risk. V5 stated she had never been told not to leave the front reception desk empty but after it happened, she was retrained and told someone needs to be up there at all times. V5 stated she had told a CNA she was going to a local fast-food restaurant before she left. V5 stated she was not sure if the front door alarm could be heard back behind the front doors. V5 stated she was gone for about 15-20 minutes after leaving at 2:15 AM but by the time she came back, R5 was gone. On 8/14/25 at 2:17 PM, V8, Licensed Practical Nurse, LPN, stated she was working when R5 got out. V8 stated a CNA came to her and said R5 was not in his bed so she got in her car and started looking for him. V8 stated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 5 she's never been R5's nurse but she noticed the aides had been checking on him often. V8 stated his nurse said R5 was in his bed just 30 minutes prior to him leaving. V8 stated she could not hear the front door alarm going off, but she thinks one of the CNAs heard it and that's what prompted everyone to start looking for R5. V8 stated R5 was not injured. V8 stated 1:1 supervision is put in place and frequent rounding is done to prevent elopements. V8 stated the staff were doing everything they were supposed to do, and it still happened. V8 stated R5's room was not close to a nurse's station or any exits and cannot be seen from a nurse's station either. On 8/14/25 at 2:34 PM, V9, CNA, stated her and V6, CNA, had been doing rounds the night R5 eloped. V9 stated V6 noticed R5 wasn't in his bed and continued to look for him then when he wasn't found quickly, the code yellow for elopement was called. V9 stated for a code yellow everyone stops what they are doing to search for the resident. V9 stated R5 had been in his room around 2:00 AM sleeping. V9 stated they do rounds every two hours and she would take turns with other staff to walk by R5's room more frequently. V9 stated V6 was in close proximity to R5 most of the night she thought. V9 stated interventions to prevent elopement are frequent checks and psychosocial staff located on each hall. V9 stated everyone was doing what they were supposed to. V9 stated she doesn't leave her section assigned and will sit on the hall. V9 stated V6 noticed first that R5 was not in his room and then noticed the front door alarm had been going off. V9 stated she was not sure how long it took for R5 to be found and doesn't think he was injured. On 8/18/25 at 11:25 AM, V11, Registered Nurse, RN stated R5 usually stays quiet in his room, he will have cigarettes outside but then goes back to bed. V11 stated every once in a while, R5 wants to leave the building but she is able to redirect him by letting him know they can get things for him like cigarettes. V11 stated R5 is usually confused that he still needs to go get things for himself like at the gas station or the bank but is reminded we can do that for him here. V11 stated 15-minute face checks are implemented for 24 hours after attempting to leave the facility and 1:1 but not sure how long for 1:1. V11 stated it is for R5's benefit to be in a facility because he requires assistance to take care of himself safely. V11 stated it is not safe for R5 to be outside unsupervised on his own because it could have the potential for him to get into an unsafe situation such as someone else being afraid of him, he's a very tall guy. V11 stated R5's room is not close to the nurse's station but is able to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 6 alternate checking on him frequently with the CNAs. V11 stated it's random when R5 is exit seeking, not sure what prompts it and not often. On 8/18/25 at 11:34 AM, V12, CNA, stated R5 is pretty chill, he comes out to eat and then goes back to lay down, at nighttime he will ask for snacks around 12:00 and go back to his room. V12 stated R5 just stays to himself, and he's never tried to leave the building while he was working. V12 stated at nighttime, if R5 is out of his room, he will try to keep him occupied and redirect him. V12 stated he keeps a close eye on all of his residents typically doing rounds every 30 minutes to an hour. V12 stated R5 doesn't have many needs. V12 stated when assigned to R5's hall it is just his hallway, and it's split with another CNA. V12 stated when he goes on breaks, he will let someone else know. V12 stated it's not safe for R5 to be outside the building on his own; he needs the assistance and direction of staff to cue him and help with his care or it won't get done and wouldn't know how to get back. On 8/18/25 at 12:33 PM, V10, Medical Director, stated he was aware R5 eloped on 8/13/25 and expects staff does everything they can to prevent. V10 stated being in a facility is necessary for R5. On 8/18/25 at 12:35 PM, V13, Nurse Practitioner, stated she was aware R5 eloped on 8/13/25. V13 stated not only is it unsafe for R5 to be outside the facility unsupervised but it is unsafe for any resident to be unsupervised outside this facility. V13 stated 1:1 supervision and frequent rounds help prevent elopement. V13 stated she expects staff to be doing frequent rounds and for staff to be at the front reception door to know that no one has gotten out. V13 stated the area this facility is in isn't the best and not many people are walking outside to begin with. V13 stated it would be suspicious to see R5 walking alone at night outside. On 8/18/25 at 3:20 PM, in a joint interview with V1, Administrator, and V14, Corporate/Regional Nurse, V1 stated on 7/6/25 R5 left the facility but staff had eyes on him the entire time until police arrived to take him back to the facility because he didn't want to come back. V1 stated R5 was then placed on 1:1 supervision for 72 hours with no signs of elopement behaviors and put on 15-minute checks after that. V1 stated R5 was trying to leave that time because he didn't have any more cigarettes. V1 and V14 stated R5's initial admission Elopement Risk Assessment was high because they do that for new admissions to be safe being in a new environment. V1 and V14 stated after that initial assessment was done, the social worker	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	**3354 JEROME LANE , CAHOKIA, Illinois, 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) COMPLETION DATE
S9999	Continued from page 7 will complete another one and update it in the records with their first visit. V1 stated the 6/23/25 assessment was high because he was new and then on 6/30/25 he was re-evaluated and deemed not at risk and that is what we were going off of prior to his elopement on 7/6/25. On 8/14/25 at 1:06 PM, the facility's video footage of R5 on 8/13/25 at 2:38 AM was reviewed and showed R5 exiting the front door of the facility unsupervised. At 2:40 AM, a person outside the front door appears but does not enter and walks away. At 2:51 AM, staff appear inside the building checking the front door. On 8/14/25 at 2:47 PM, the facility's video footage was reviewed and showed R5 returning to the facility on 8/13/25 at 3:36 AM accompanied by staff. On 8/14/25 at 1:05 PM, V1 activated the facility's front door alarm and went back to where the floor staff would be (past two double doors after walking in the front entry doorway. V1 stated she could not hear the alarm. This surveyor went past the double doors where staff would be working behind and could not hear the front door alarm. V4 (receptionist) stated the front door alarm could not be heard past the double doors. The facility's Elopement Policy last reviewed on 9/2022 documented 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. The policy further documented elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so. It continued to document alert residents are not in the same category of potential danger as the resident with impair cognition trying to leave the facility. (B)	S9999		