

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057489		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/22/2026	
NAME OF PROVIDER OR SUPPLIER BRIA OF WOODRIVER				STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD , WOOD RIVER, Illinois, 62095			
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S0000	Initial Comments		S0000				
	Complaint Investigation:						
	25411490/2677265						
	25411513/2678372						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 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 These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to provide supervision to prevent elopement for 2 out of 2 residents (R2, R4). This failure resulted in R2 eloping through the front entrance at 2:05 AM unsupervised and the facility being notified of his location 4.4 miles away at 10:52 AM. This failure resulted in R4 eloping from the front door and being found across a busy two-lane road that borders the front of the facility approximately 500 feet away from the entrance at 1:27 PM. Findings include: 1. R2's face sheet documented he was admitted to the facility on 5/29/23 with diagnosis of, in part, aphasia, acute and chronic respiratory failure, dementia with agitation, major depressive disorder, schizophrenia, facial weakness following cerebral infarction and unsteadiness on feet. R2' Minimum Data Set (MDS) dated 9/25/25, documented R2 to be severely cognitively impaired, requiring partial/moderate assistance from staff to transfer from bed to chair/chair to bed. R2 also utilizes a wheelchair and requires supervision or touching assistance to wheel 50 feet and when making two turns. R2 was unable to be interviewed due to dementia diagnosis. R2's Care Plan dated 6/1/23 documented R2 is at risk for elopement with interventions for staff as follows: on 6/1/23 incorporate diversional activities, on 6/8/23 friendly approach and wander guard as ordered on 6/15/23 redirect from exit doors and show him his room. R2's Care Plan dated 5/31/23 documented wander guard placement with the following interventions for staff to complete: check function of wander guard as ordered,		S9999				

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S9999	Continued from page 2 monitor every shift for placement and proper function of wander guard, replace wander guard every 90 days and document location of replacement as ordered. R2's Care Plan dated 6/13/23 documented he requires assistance with daily care needs with an intervention to provide assistance with ADLs (activities of daily living). R2's Care Plan dated 6/13/23 documented he is at high risk for falls related to impaired safety awareness, use of psychotropic medication, incontinence, impaired balance/coordination with right side weakness. R2's Elopement Risk Assessments dated 12/29/23, 3/12/24, 6/11/24, 8/3/24, 8/17/24, 9/10/24, 12/10/24, 1/28/25, 3/28/25, 4/25/25, 6/14/25, 6/26/25, and 9/25/25 all rated R2 to be at high risk. The local Fire Department's Incident Report dated 11/22/25 at 9:12 AM documented, "V6 (Deputy Chief) received a text message from Capt. (captain) stating that the facility was requesting access to our department camera system due to a missing resident. V6 responded to the station and was given contact information for the ADON, V3, who V6 spoke with by phone. V3 stated that a male PT (patient) was last accounted for at 0230 (2:30 AM) this morning and is wheelchair bound. V6 reviewed the camera footage from 0230 to the present time and was unable to locate anything. V6 updated V3 with this information. V3 informed V6 that the facility now believes that R2 exited the facility at 0205 (2:05 AM). V6 was quickly able to locate footage on the front and west side cameras at 0206 (2:06 AM) showing R2 in a wheelchair moving east on the road to the facility to the entrance of a neighboring assisted living facility and stopping for about 10 minutes before moving west and out camera view at 0228 (2:28 AM), V6 called and updated V3 with this information and began checking the area.....Employees of gas station (approximately 0.1 miles from facility's entrance) confirmed that R2 was sitting in his wheelchair in the neighboring lot at 0315 (3:15 AM) this morning. Shortly after while still driving the area, V3 called and stated that he was located at a residence in neighboring unincorporated community (approximately 4.1 miles away). All FD (fired department) units returned to service." The local Police Department Report dated 11/22/25 at 8:31 AM documented they responded to a report of a missing person from the facility. The report continued to document, "V36 (assigned police officer) reviewed video footage from the facility and observed the following: 2:01am R2 sitting in his wheelchair in the front lounge area; 2:05am R2 exiting the front doors of the facility." The report documented V36 was informed	S9999					

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S9999	Continued from page 3 at approximately 10:52 AM that R2 was located (at an address in a neighboring unincorporated community). R2's Nurses Notes dated 11/22/25 at 12:17 PM, documented, "Writer noticed resident was not in the building at 0805 (8:05 AM) when trying to distribute medication to patient during morning medication pass. R2 was not in his room, dining room, or the front lobby. Writer and staff searched the building and discovered resident was not in the building. Writer then called Administrator at 0823 (8:23 AM) and was instructed to search building and surrounding areas and then to contact the police if resident was not located. Staff assisted writer and placed a call to the local police department at 0830 (8:30 AM) staff looked for R2 in surrounding areas. Staff nurses assisted writer by updating family at 0830 (8:30 AM). Police arrived and collected story data on events occurred." Global Positioning System (GPS) documented the address R2 was found 4.4 miles away and would take approximately one hour and 36 minutes for someone to walk to. R2's Incident Report dated 11/22/25 documented resident was reported to be missing from the facility. R2 stated he was hungry, predisposing physiological factors included gait imbalance and weakness/fainted. The report continued to document that R2 was in a wheelchair, and assessed on return with no concerns, placed on 1:1 (one on one) precaution. R2's Elopement Investigation of 11/22/25 did not include any interview statements from the night staff providing care for R2. The Investigation included a statement from V28 (Dietary Manager) stating she was called in on 11/22/25 and at 9:00 AM when R2 was reported missing. V28 documented she got to a business down the street and was told a man was pushing R2 in his wheelchair. The investigation also included a statement from V37 (R2's day shift CNA 11/22/25) stating she came into work to do her morning shift which is from 6AM-2PM. V37 stated she reported to 200 hall and started working. V37 stated as breakfast approached, the nurse asked her if R2 was in his room and he wasn't there to receive his breakfast tray, so they did a headcount and noticed he was missing. The Investigation included a statement from V16 (R2's day shift LPN 11/22/25) documenting she was notified that R2 was not in his room, bathroom, or common areas and reported to the administrator, DON and other staff that R2 was missing. V16 stated she went from room to room, and outside around the parameter to search for R2 and then notified R2's family.		S9999				

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S9999	Continued from page 4 R2's Medication Administration Note dated 12/9/25 at 5:49 PM documented there was no wonder guard. R2's Medication Administration Note dated 12/11/25 at 6:00 AM documented his wander guard was not available. R2's Medication Administration Note dated 12/17/25 at 2:25 PM documented his wander guard was not in place. R2's Medication Administration Note dated 12/19/25 at 2:37 AM documented, "resident is not wearing his wander guard ADON (assistant director of nursing) is to be at the facility in a couple of hours will request a new one from her as soon as she arrives, have informed all staff and will be monitoring resident closely." R2's Medication Administration Note dated 12/22/25 at 12:20 AM, documented no wander guard in place. R2's Medication Administration Note dated 12/23/25 at 12:51 AM, documented no wander guard in place. R2's Medication Administration Note dated 12/24/25 at 3:09 AM, wander guard attached to R2's wheelchair. R2's Medication Administration Note dated 12/27/25 3:04 PM documented his wander guard was not on person, DON (director of nursing) aware, resident refuses to wear. On 1/12/26 at 9:30 AM, V6 (Deputy Fire Chief) stated on 11/22/25 at 9:15 AM, the facility was needing access to our security cameras (the fire station is two buildings over from the facility and seen from entrance). V6 stated he wasn't sure what time to look at first but later was told around 2:00 AM and we were able to see the resident leave the facility in a wheelchair, and it was cold outside. V6 stated the resident wheeled himself next to the front entrance by the bushes of the apartments located between the facility and the fire station and sat there for about 15 minutes. V6 stated the resident then went west on the road and out of view. V6 stated the gas station down the street was able to confirm they saw a man in a wheelchair that night. V6 stated he couldn't remember what the resident was wearing or more details at this time. V6 stated the facility did have camera footage of the resident though because they confirmed the time he left the facility for us. On 1/12/26 at 1:58 PM, V1 (administrator) stated R2 eloped around 2:00 AM and by 10:30 AM he was brought back by police. V1 stated she wasn't sure if she requested the video footage but will look to see if		S9999				

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S9999	Continued from page 5 they have it. V1 stated R2 got out the front door and his nurse that night said he'd been up in his wheelchair and last seen at the nurse's station around 1:30-2:00 AM. V1 stated she thinks his nurse that night was V8 licensed practical nurse (LPN). On 1/12/26 at 2:11 PM, V7, Registered Nurse (RN) stated she realized at 8:00 AM on 11/22/25 that R2 was missing, her shift started at 6:00 AM. V7 stated the nurse she received report from reported R2 was fine and had no concerns. V7 stated the CNA (certified nursing assistant) working with R2 did not report anything to her about R2's elopement. V7 stated she wasn't aware of R2 eloping prior to 11/22/25 and R2 was not at risk for elopement. V7 stated she checked the building first, got others to help, then about 15-20 minutes later called the administrator. V7 stated R2 had a wander guard, and it's supposed to sound when residents get close to the door. V7 stated R2 is alert and oriented times three but not safe to be off the premises without supervision. V7 stated everyone gets a wander guard if they move around independently. V7 stated R2 is typically cooperative, easy going and her main focus is getting R2 his medications. On 1/12/26 at 2:30 PM, V1, administrator stated another resident (R3) returned that night from a LOA (leave of absence) right before R2 got out the door. V1 stated R2 got out the front door before it could reset the alarm. V1 stated the wander guard also alarms when it gets within six feet of the exits, and we have eight total exits. V1 stated the wander guard alarm sounds only at the door. V1 stated R2 was not wearing his wander guard that night, he had removed it and it was found torn apart in his room. V1 stated R2 agreed to have his wander guard placed on the back of his wheelchair a week after the incident. V1 stated R2 would not be safe leaving the facility unsupervised without staff and on his own. On 1/12/26 at 2:43 PM, V11 (CNA working the night of 11/21/25-11/22/25), stated she didn't even know R2 was gone. V11 stated she overheard R2's aide tell R2's nurse they couldn't find him and his nurse responded saying she saw R2 going towards the vending machine not too long ago but neither one of them actually laid eyes and looked for R2 after that; they just continued working. V11 stated when she came back another day, she found out R2 had left that night right after another resident came back. V11 stated R2 was typically quiet, he'd get fussy if he doesn't get seconds of food, but he's cool just tends to himself and not a problem, likes to sit up front and stare out the window. V11 stated R2 was not an elopement risk. V11 stated R2		S9999				

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S9999	Continued from page 6 would not be safe by himself on the streets at night without supervision. On 1/13/26 at 2:06 PM, V8, Licensed Practical Nurse (LPN R2's night nurse on 11/22/25) stated she didn't question where R2 was that night because she saw him at the nurse's station at 2:30 AM and the building is completely alarmed, all the exits have alarms on them, and none went off. V8 stated R2 had just gotten up and came by the nurse's station at 2:30 AM, then went towards the back of the building. V8 stated R2's aide never brought concerns to her about his whereabouts. V8 stated around 4:30 or 5:00 AM R2's aide asked her if she had seen him, and she told them that she had seen R2 at 2:30 AM then the aide went back down the hall and didn't say anything else. V8 stated R3 did return to the facility around 2:00 AM, we didn't let him in, he comes and goes all the time, so he has the code. V8 stated she rounds on residents every 2 hours but R2 doesn't like to be bothered and closes his door. V8 stated R2 is independent so she personally doesn't open it his door to his room and go in. V8 stated she probably saw R2 two or 3 times that shift. V8 stated R2 usually doesn't get up at night and he didn't say why he was up. V8 stated there is no way you can confirm someone's safety without seeing them with rounds. V8 stated R2 is not safe outside unsupervised. V8 stated she doesn't think R2 had a wander guard and doesn't remember him being at risk for elopement. On 1/13/26 at 11:01 AM, V10 (CNA), R2's assigned aide the night of 11/21/25-11/22/25), stated they didn't find out R2 eloped because the nurse assigned to R2 told them they had seen R2 that night. V10 stated they were told R2 was independent in report. V10 stated they were told after coming back from break around 2:00 AM that night that R2's nurse V8 had seen him 5 minutes prior up in the front lobby. V10 stated around 5:45-5:50 AM they asked the nurse again if she had seen R2 and she responded saying R2 had rolled up to breakfast. V10 stated they had rounded on R2 once that night and saw him in his bed but was later told by staff that it was actually R2's roommate in R2's bed. V10 stated they just assumed it was R2. V10 stated they were not informed R2 was at risk for elopement. V10 stated they saw R2 once during their first set of rounds and they do 4 rounds a shift. V10 stated they like to round on the residents every 2 hours or every hour and 30 minutes. V10 stated they were concerned they hadn't seen R2 that night but reported their concerns to the nurse and the nurse said she had seen R2. V10 stated they asked the nurse two times that night where R2 was. V10 stated the nurse would have had to pass R2 medications before leaving and never heard		S9999				

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S9999	Continued from page 7 that he was missing. V10 stated R2 didn't have a wander guard on that night and nothing to indicated R2 was at risk for elopement. V10 stated no one informed them R2 was at risk for eloping either. V10 stated no one mentioned a binder of residents at risk for elopements that would be available. V10 stated R2's nurse assured them of R2's safety. V10 stated it would pose a safety risk for R2 to be out unsupervised. V10 stated it is protocol to do a head count if someone elopes or goes missing. On 1/13/26 at 11:15 AM, V19 (LPN) stated she worked 11/21/25 until 10:00 PM and gave report to V8, (LPN). V19 stated R2 appeared normal at the time, and not at risk for elopement that she was aware of. V19 stated she could find out who is at risk for elopements through the electronic health records and what residents wear wander guards. V19 stated R2 has been getting his wander guard off recently but can't remember if he was wearing one that night. V19 stated R2 went to bed before she left. V19 stated R2 is usually quiet, takes his medications, needs assistance with supervision, and set up assistance. V19 stated R2 would not be safe unsupervised outside mostly because he doesn't communicate well, doesn't comprehend well, and his cognitive state is concerning. V19 stated important things to prevent R2 from elopement is making sure R2's wander guard is on and that he gets his sleep, or he gets agitated, and rounding every two hours. V19 stated you would not be able to confirm someone's safety if they aren't rounded on. V19 stated she doesn't know the details of R2 elopement. On 1/13/26 at 1:12 PM, V3 (ADON) stated R2 was able to remove his wander guards before so they decided to place it on his wheelchair instead. At 1:25 PM, V3 stated R2 took off his wander guard in his room that night and that's where it was found. On 1/13/26 at 10:00 AM, V14 (Lead CNA) stated R2 is independent, stays to himself, and likes to go to the front lobby. V14 stated R2 eloped a couple months ago; he got out the front door at night, but she doesn't know details. V14 stated they have an elopement risk book at the nurse's station where she can find out who is at risk for elopement. V14 stated everyone was in-serviced on elopements. V14 stated she keeps an eye on R2 mostly as prevention for elopement. V14 stated R2 requires supervision assistance with ADLs, he always uses his wheelchair, never walks, he gets confused. V14 stated it would be concerning if she overheard other staff talking about not knowing where a resident was and didn't go find them. V14 stated if she overheard that, she would go look for the resident and find them.		S9999				

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S9999	Continued from page 8 V14 stated she rounds every 2 hours and it is concerning if a resident didn't get rounded on for 6 hours, it poses a threat to their safety. V14 stated some precautions for elopements are having the risk book, in-services, and wander guards. On 1/13/26 a 10:09 AM, V15 (CNA) stated R2 is mostly quiet, stays to himself, and is up in the front lobby a lot. V15 stated R2 requires supervision assistance or set up and likes routine. V15 stated R2 eloped once a month ago but doesn't know details. V15 stated she makes rounds every 2 hours. V15 stated you cannot confirm a resident's safety without making rounds. V15 stated it would be concerning to overhear staff talk about not seeing a resident, then proceed back to work without laying eyes on that resident. V15 stated she would go find the resident if she overheard someone hadn't seen them and if not found start the process for elopement. V15 stated the wander guard is a bracelet that alarms if close to a door and you must disarm it to turn it off. V15 stated for elopements they do one on one supervision, frequent rounding, wander guard checks, and make sure you have an eye on the residents and inform others when you are leaving. V15 stated R2 would not be safe unsupervised outside. V15 stated there is an elopement risk book at the nurse's stations where she can find out who is at risk. On 1/13/26 at 10:35 AM, V17 (LPN) stated R2 has never eloped that she is aware of, and she isn't sure if he is at risk for elopement. V17 stated interventions set for elopement risks could include frequent monitoring, wander guards, and two-hour rounding. V17 stated you cannot confirm someone's safety without having eyes on them. V17 stated it would be concerning if she overheard staff talking about a resident they hadn't seen and didn't find them. V17 stated she would go and check for the resident. V17 stated in-servicing and signing off on rounds would be important to prevent elopements. V17 stated if a wander guard is in place, it will alarm when it gets too close to the door no matter what. V17 stated if the wander guard doesn't alarm it isn't working appropriately. On 1/13/26 at 10:42 AM, V18 Social Services Director (SSD) stated she was not working at the time of R2's elopement. V18 stated the MDS nurse does the elopement assessments and then we discuss concerns and everyone at risk gets a wander guard. V18 stated important interventions for elopement risks are putting eyes on the residents and following up on alarms. V18 stated R2 likes to sit up front a lot, eats in his room, is not too social, is confused, forgetful and sometimes needs redirecting especially when he gets agitated. V18		S9999				

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S9999	Continued from page 9 stated R2 is not safe to be outside in the middle of the night alone. V18 stated she heard R2 got out around 2:00 AM and everyone looked for him at about 4:00 or 5:00 AM and was found around 11:00 AM in a nearby village where he is from. V18 stated she is not sure why he got out. V18 stated you cannot confirm someone's safety without seeing and rounding on them. V18 stated they now have a receptionist up front 24hours a day in place. On 1/13/26 at 11:29 AM, V20 (Acting SSD) stated her involvement in R2's behavior management program is following the policy. V20 stated she would have to look to see if R2 has always been at risk for elopement. V20 stated she was the social services director working at the time of R2's elopement and continued until 1/6/26. V20 stated her concerns were with safety on R2. V20 stated she covers 7 facilities. V20 stated she is involved in care plans and updating risks and has been involved since she took over at the facility. V20 stated she would have to look up what R2's risk factors are for elopements. V20 stated interventions for elopement include wander guards and frequent rounding depending on the risk. V20 stated nothing comes to mind that is concerning R2. V20 stated all staff are responsible for reporting missing residents. V20 stated she does not know any of the details on R2's elopement. V20 stated they hold care plan meetings at the president's request and quarterly. On 1/13/26 at 12:01 PM, V4, RNC Registered Nurse Certified stated V20 (Acting SSD) should know details on what's going on in her building and everyone is supposed to be in-serviced. On 1/13/26 at 12:38 PM, V21 (Restorative CNA) stated R2 is pretty chill, struggles with communication and being understood, he can be argumentative and likes to hang out by the lobby looking outside. V21 stated R2 has been a high risk for elopement since he arrived. V21 stated R2 has not had an attempt to elope since 11/22/25 and never exit seeking. V21 stated R2 is a one assist with bathing, supervision mostly with ADLs, wheels himself around, is sometimes out of breath and has received breathing treatments. V21 stated R2 is not safe to be out unsupervised. V21 stated she rounds on residents every two hours. V21 stated R2 was found near his old house. V21 stated you cannot confirm someone's safety without rounding for 6 hours, and that is neglecting their safety. On 1/13/26 at 1:16 PM, V23 (Receptionist) stated R2 stays up front in lobby a lot, noted to get agitated if it's noisy. R2 keeps to himself and is quiet, V23		S9999				

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S9999	Continued from page 10 stated R2 doesn't display exit seeking behavior. V23 stated there is a nighttime receptionist at the front now but not when R2 eloped. V23 stated she was called that day and came in to look for R2. V23 stated R2 pulls his wander guard off and would refuse to wear it on his body so she decided to put it on his wheelchair instead. V23 stated R2 is always in his wheelchair, he can't walk. V23 stated R2 would not be safe outside unsupervised mostly because he gets confused easily with his dementia which is concerning. On 1/13/26 at 1:35 PM, V3 (ADON) stated that any time the door is opened the alarm will sound. V3 went to the front door to set off the alarm while this surveyor stayed at the nurse's station to hear the alarm. No alarm was activated or heard. On 1/13/26 at 1:37 PM, V24 (Maintenance Director) came to the nurse's station and adjusted the alarm box on the wall. Immediately two alarms went off, one for north exit and one for high corridor (neither one the front doors). The alarms were very loud and were turned off by pressing a button that is lit up. At 1:57 PM, V24 (Maintenance Director) stated the north door is an employee access door and smoke door so it has high traffic as well as the front lobby door, so they have different settings for the rest of the exits. V24 stated the front door and north door do not sound alarms at the nurse's stations like the rest of the doors or they'd be going off all the time. V24 stated both of those doors have been that way; it hasn't changed. V24 stated they are getting a new system soon. V24 stated R2 must have known if you hold down the door lever for 15 seconds it automatically unlocks and lets you out there's no other way he could have gotten out that night. V24 stated there is an alarm on the front lobby door if it opens but the sound will only go off up there. V24 stated the door has functioned appropriately to his knowledge. On 1/13/26 at 2:25 PM, V3 (ADON) stated the front lobby door doesn't alarm at the back where the nurse's stations are, V24 (Maintenance Director) just told her that it is a high traffic door, so we have someone up front all the time. V3 stated we did not have someone at the front the night R2 eloped. V3 stated she would find out when they started having the door supervised 24 hours a day. At 2:31 PM, V3 stated they started supervising the front door 11/22/25. On 1/14/26 at 9:06 AM, V22 Human Resources (HR) stated she did not know the front door wouldn't alarm at the nurse's stations.		S9999				

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S9999	Continued from page 11 On 1/13/26 at 4:04 PM, V4 stated she would expect nursing staff to be rounding on the residents at minimum of every 2 hours and more if required. V4 stated rounding consists of knocking on the door, checking on the resident, checking if they are breathing, safe, checking on IV's or tube feedings, indwelling catheters, wounds, their comfort, positioning and making sure the resident is seen. V4 stated she could not confirm a resident was safe if they were not seen, which is why they round. V4 stated she was not aware the front door did not alarm to the nurse's stations. V4 stated she expects staff to do their jobs. On 1/14/26 at 12:28 PM, V2 (DON) stated R2 loves to be up in the front of the building by the birds, talking to V23 (receptionist), going to the vending machines, eating in his room but does not like when other people are with him while he eats. V2 state R2 needs touching/hands on assistance with his ADLs, cannot transfer himself alone, is always in his wheelchair, has never seen him walk. V2 stated R2 was rated high risk for elopements because when he first got here, he made attempts to get out. V2 stated they placed the wander guard on him when he had originally made those attempts. V2 stated he was always trying to remove the wander guard and is not compliant with it. V2 stated she expects staff to make 2-hour rounds, putting eyes on the residents, and if they are not seen staff will report to the nurse and continue to look and follow policy. V2 stated there are elopement binders now at the nurse's stations with pictures of the at-risk residents and their medical conditions, also they have been in-servicing on elopements with all the staff including agency but prior to R2's elopement she is not sure what was being done or in place. V2 stated the aide should lay eyes on a resident if they haven't seen them and were told the last where abouts were 5 minutes ago. V2 stated R2 was up all night that night when another resident came in the front door at 2:00 AM. V2 stated she saw the camera footage of R2 going to the door before it was able to reset and pushed it open. V2 stated R2 was not wearing his wander guard, and no alarms went off. V2 stated the resident that returned put in the code himself with no staff to let him in and residents are not supposed to have the code. V2 stated they've had to change the code many times. V2 stated she's not 100% sure how the front door alarm works, V24 tried to explain it to me, just know it's a high traffic door. V2 stated she would have expected someone to have noticed R2 was gone between the 6 hours of 2:00 AM and 8:00 AM. V2 stated they cannot confirm R2's safety while he eloped. V2 stated R2 was not safe to be outside unsupervised he could have gotten hit by a car,		S9999				

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S9999	Continued from page 12 which could have led to serious harm or death. V2 stated R2 was found near his old house which is now torn down. V2 stated R2 had no injuries. At 1:26 PM, V2 stated she was the first to get to R2 along with V24 after R2's old neighbor recognized R2 and called the facility. V2 stated R2 was sitting outside, no injuries noted. V2 stated R2 didn't want to leave and told her he was going to stay. V2 stated R2 told her he went to a fast-food place to get food also. On 1/15/26 at 9:54 AM, V2 (DON) stated her expectations for frequent monitoring entails every two-hour rounding for those needing close supervision that R2 was. On 1/15/26 at 9:48 AM, V24 (Maintenance Director) stated R2 didn't want to come back when they found him. V24 stated R2 rode back to the facility with the police. V24 stated R2's old neighbors recognized him and called us when he got out. V24 was the first one to get to R2 and he didn't look hurt in any way, he was feeling good and said he was going to stay there. V24 stated R2 didn't mention how he was able to get to where he was found but there's no way he got there on his own in his wheelchair and he must have been on concrete, no way he could get through grass in his wheelchair either. On 1/15/26 at 8:22 AM, V1 Administrator, stated the wander guard is what is put in place as an intervention for residents with concerns of supervision. V1 stated she will have someone supervising the front door 24 hours a day and the front door alarm can be heard from the back nursing stations. V1 stated there is no policy for rounding but our expectations were added to the daily staffing sheets starting sometime in December she thinks which state every two-hour check/change/reposition for all rooms on assignment under CNA Duties. At 11:01 AM, V1 stated she wasn't at the facility during the initial investigation for R2 but the regional nurse at that time was in charge of it. V2 stated she didn't think to add interviews of any staff members that were working the night R2 eloped. V2 stated she did talk to the nurse on the phone but didn't type up the interview. On 1/13/26 at 3:44 PM, V26 Medical Director (MD) stated he cannot confirm someone's safety without seeing them. On 1/14/26 at 10:52 AM, V26 (Medical Directo) stated there's a safety risk for R2 while he eloped. V26 stated you could not make sure R2 was safe from harm during the time he eloped. V26 stated R2 was not a high risk for elopement prior to his elopement and when questioned about R2 having been rated high risk prior,		S9999				

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S9999	Continued from page 13 V26 stated he would have to defer to the facility on their assessment scores. V26 stated given the facility's expectations of rounding being done, he would have expected them to have seen him during those 6 hours. V26 stated R2 being outside in the middle of the night is a safety concern and supervision is necessary to keep him safe from harm. On 1/12/26 at 1:45 PM, Surveyor observed R2 sitting in his wheelchair at the front lobby by the bird cage looking out the window. R2 had a wander guard strapped to the back of his wheelchair. R2 stated he usually hangs out here, they won't let him leave and he's never left the facility or gotten out. R2 is unable to answer questions appropriately about his care. On 1/13/26 at 1:11 PM, V4 and V3 (ADON) took R2 near the front door with his wander guard in place. The alarm went off when R2 was within 6 feet of the front door. V3 then went outside and put in the door code, walked inside and waited 10 seconds before attempting to open the front door again and was unable to, it was locked. On 1/15/26 at 12:07 PM, staff held down front door handle for 15 seconds, the door unlocked and opened, the alarm sounded until deactivated by receptionist. 2.R4's Face sheet documented she was admitted on 10/20/25 with diagnosis of, in part, asthma, cognitive communication deficit, schizophrenia, and encounter for surgical aftercare following surgery on the digestive system. R4's MDS dated 10/27/25 documented her to be cognitively intact with hallucinations and delusions, requiring supervision with all transfers and walking. R4's Care Plan documented on 10/30/25 she was at risk for elopement related to her delusions, and stating intent to leave with interventions for staff as follow: on 10/30/25 1:1 with staff as needed, 15-30 min checks as needed, allow concerns to be expressed, check placement/function of wander guard every shift, replace wander guard every 90 day, may use wander guard to monitor resident for safety, encourage resident to keep busy with activities, MD notification PRN (as needed), monitor where abouts PRN, and redirect resident to activities of choice or SS (social services) group. R4's Care Plan dated 11/6/25 documented she is at risk for alteration in mood/psychosocial status related to being a new admit, diagnosis of schizophrenia and she has delusions and a history of hallucinations. R4's Elopement Risk Assessments dated 10/30/25 and		S9999				

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S9999	Continued from page 14 11/22/25 documented she was at high risk and that R4 was not sufficiently alert, oriented and coherent enabling her to be considered for independent outside pass privileges with an MD order and appropriate compliance with any behavior management program/system/interventions. R4's Incident Report dated 12/7/25 documented, "kitchen staff reported that a resident exited the facility. Kitchen staff went to determine who the resident was. She was walking away from the facility. Staff went out to her and brought her back to the facility. Resident remained in line of site from time she exited to time she returned. Resident Description: Resident states she was going to the bus stop. Resident returned to the facility with staff; she was placed on a 1: 1. Placed a person at the front door 24 hours a day." The report documented R4's predisposing situation factors included being an active exit seeker. The report continued to document, "It was determined from interviewing the resident that she was going to the bus stop so that she could go see her daughter. She feared her daughter was being held in a basement and she needed to go rescue her." R4's Elopement Investigation for 12/7/25 included a witness statement from V28 (Dietary Manager) stating, "Sunday December 7th around 1pm I was in kitchen talking to my staff, housekeeper (V30) and a resident family member alerted us that someone was running off so I and my staff ran outside to visualize that R4 had in fact ran across the road..." V28's statement continued to document that they caught up to R4 at the stop sign. V28 stated that R4 told them her daughter was coming, and she had to catch the bus. On 1/20/26 at 3:25 PM, R4 stated she used to live with her son, and he is her guardian but doesn't know why. R4 stated she is followed by staff here constantly because she tried to go to the bus stop a couple months ago after her son said he was going to pick her up. R4 stated the door was unlocked, so she left. R4 stated she feels like a bother to be here having to wait for the staff to do anything. R4 stated she needs to get out of here and thinks her son is working on her discharge. R4's wander guard was not in place. On 1/12/26 at 9:43 AM, requested V1 (Administrator) to provide any FRI's (facility reported incidents) and elopements since October of 2025. On 1/12/26 at 11:14 AM, V4 (RNC) stated R2 was the only elopement they had since October 2025, they had another issue, but the resident was still in eyesight, so we		S9999				

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S9999	Continued from page 15 didn't include that as an elopement. On 1/14/26 at 12:28 PM, V2 (DON) stated there was one other elopement she did not consider an elopement because staff had eyes on R4 the entire time, but other than R2 that was the only one for the last 6 months. V2 was requested to provide the investigation on R4's incident. On 1/13/26 at 10:42 AM, V18 (SSD) stated they had one other elopement risk resident (R4) who is on 1:1 (one on ones) right now and has been on that for a while. V18 stated she doesn't know if R4 got out but heard she started running out the door. V18 stated staff had eyes on her when she ran and a kitchen staff got her at the bus stop, that's only what she heard. On 1/15/26 at 11:57 AM, V28 (Dietary Manager) stated on 12/7/25 she was in the kitchen when V30 (Housekeeping) and a family member came and informed her a resident had got outside the front door. V28 stated R4 was very confused, she said she was going to the bus stop because her daughter was going to pick her up. V28 stated the family member said at first, she was running back and forth outside the entrance. V28 stated no other staff were outside with R4 before V29 and V30 arrived. V29 stated R4 was running and was able to get across the street. V28 stated the facility did in-servicing on elopements after R2 eloped in November. On 1/15/26 at 12:05 PM, V29 (Dietary Aide) stated V30 (housekeeping) came to say R4 had gotten out and was already across the street by the stop sign. V29 stated he had to run to get to her and he wasn't able to see her cross the street. V29 stated no alarms were going off. On 1/15/26 at 12:09 PM, V30 (housekeeping) stated a family member told him a resident got out the front door and had already taken off running. V30 stated R4 had already gotten to the stop sign across the street. V30 pointed out from the front lobby to a stop sign approximately 500 feet away from the facility that was located across a busy two-lane road. V30 stated, "I had to book it to get to her." V30 stated the family member told him R4 got out after a staff member opened the door. On 1/15/26 at 12:30 PM, V15 (CNA) stated she started taking care of R4 after she started getting one on ones (1:1) assigned. V15 stated R4 is quiet, to herself, and she had a wander guard at first, but she returned once from a Leave of Absence (LOA) without it and never got another one. V15 stated R4 probably doesn't need a		S9999				

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S9999	Continued from page 16 wander guard now that she is 1:1. On 1/15/26 at 12:42 PM, V31 (CNA) stated prior to R4's elopement, R4 stayed in her room most of the time, occasionally she would go sit near the exits by the dining room and front lobby which always set the alarms off from her wander guard. V31 stated R4 was having exit seeking behavior but she continued to be independent, we would just redirect R4, reset the alarms, nothing else was put in place besides the wander guard. V31 stated she wasn't sure why R4 was placed on 15-minute checks in November she doesn't remember R4 ever getting out prior to 12/7/25. On 1/15/26 at 12:56 PM, V32 (CNA) stated prior to R4's elopement in December she stayed in her room, mostly independent, she had a wander guard on and would set the alarms off a lot. V32 stated she would respond to R4 setting off the door alarms, would redirect her and reset the alarm, but nothing else was put in place until after she got out, then she was placed on 1:1. V32 stated she noticed R4 would get out of her room more after she would go on LOA's. V32 stated R4 smoked outside supervised. V32 stated she rounded on R4 every two hours. V32 stated she was in-serviced on elopements and noted the elopement policy and procedures with no concerns. V32 stated right now there is approximately 9-10 high risk for elopement residents in the binders. On 1/15/26 at 1:21 PM, V1 (Administrator) stated she could not confirm or deny R4 would have been safe from any harm at the time she got out of the facility 12/7/25. V1 stated R4 cannot sign herself out, her son is her legal guardian. The facility's Elopement policy with last review date of 9/2022 documented elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The policy also documented that 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. (A)		S9999				