

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Nexus Pavilion at Belleville		STREET ADDRESS, CITY, STATE, ZIP CODE 727 North 17th Street Belleville, IL 62226	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility failed to ensure residents were being monitored and supervised to prevent elopement for 1 of 3 residents (R2) reviewed for supervision to prevent elopement in the sample of 11. This failure resulted in R2 attempting to exit the facility around 2 AM on 6/10/2025. R2 was redirected but no other interventions were implemented and R2 then later eloped from the Facility on 6/10/2025 at 5:49 AM and was sent out to the hospital for six days with a diagnosis of Paranoid Schizophrenia and behaviors.</p> <p>The Immediate Jeopardy began on 6/10/25 when the facility failed to implement resident-centered interventions after R2 previously displayed exit seeking behaviors to prevent R2 from eloping the facility again the same day. V10, Regional Nurse Consultant, and V2, Director of Nursing (DON), were notified of the Immediate Jeopardy on 6/20/25 at :4:05 PM. On 6/25/25, the surveyor confirmed through observation, interview, and record review that the Immediate Jeopardy was removed on 6/23/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of in-service training and current policy and procedure regarding elopement.</p> <p>Findings include:</p> <p>R2's Physician Order Sheet (POS) dated June 2025 documents diagnoses of Paranoid schizophrenia, muscle weakness, cognitive communication deficit, hypertension, drug induced subacute dyskinesia, anemia, allergic rhinitis, and primary generalized osteoarthritis.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] document R2 was cognitively intact for decision making of activities of daily living. R2 has no impairment and walks independently with minimal assist for most activities. R2 does not have or wear a (resident wandering/monitoring device) management system.</p> <p>R2's Care Plan date initiated 1/19/2023, (R2) is at risk for elopement. He has a history of leaving facilities by climbing out his window. Provide one on one should resident attempt exit seeking behaviors. Date initial 7/30/2020. Redirect resident when he is exit seeking (Revision date 7/30/2020). R2's Care Plan does document ROM (Range of Motion): is at risk for developing an impairment in functional joint mobility. (R2) has impaired functional mobility to both upper and lower extremities r/t (related to weakness and inactivity). (R2) has a DX (diagnosis) Paranoid schizophrenia. He is at risk for impaired social interaction, disturbed sensory perception, defensive coping and disturbed thought process (revision date of 3/21/2025).</p> <p>On 6/12/2025 at 4:49 AM, R2's photo was at the nurse's station in a binder book labeled Elopement.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R2's Nurse's Notes dated 6/10/2025 at 6:43 AM, Resident left out of facility back door. Writer was notified at 6:23 AM. Resident was found in shed on property yard at 6:30 AM. Brought resident back to facility via walking with staff. Resident has a history of elopement and is being sent to hospital for evaluation. (Author V9, Licensed Practical Nurse, LPN).</p> <p>On 6/25/2025 at 2:21 PM, V9, stated I am agency nurse and had only worked in that facility a few times. I started my shift around 10:30 PM, and I did not see (R2) go out of the building. I really do not remember much except (R2) got out during shift change. Again, this was only my second time working in that building. Nobody from the facility took a statement from me.</p> <p>On 6/12/2025 at 4:49 AM, V6, LPN stated, (R2) is exit seeking at times. (R2) had gotten out of the building off the 400-smoke door. I was working when (R2) got out. No staff actually saw him leave, but when he opened the door, it set off the alarm. They found him later in a shed. This all happened during shift change. He was gone for about 10-15 minutes. I know the nurse supervisor (V8) received a call telling her (R2) had gotten out of the building.</p> <p>The Facility did not provide any statement from V6 regarding R2 eloping and/or attempting to elope on 6/10/2025. No statement was provided, and all statements were requested.</p> <p>On 6/12/2025 at 6:03 AM, V7, Certified Nursing Assistant (CNA) stated, I was on the 400-hall earlier doing a one on one with another resident. About 2 AM, I saw (R2) pacing and attempting to exit, and I went and redirected him, and he did not say anything but easily took my suggestion and went back into his room. I then went and notified the nurse on that hall that we needed to put the lights on so we could see better in case (R2) attempted to exit again. A few hours later, I know it was in the middle of shift change, I heard the alarm go off and looked up saw the door on the 400-hall smoker door closing and I went chasing after (R2) yelling for staff to watch my resident. By the time I got there, I lost sight of (R2). He was fast. He was also dressed and wearing an orange jacket. He was gone, I would say he got out about 5:50 AM. Staff came running and they were all outside looking for (R2). I did not call the police, and I am not aware of anyone calling the police. They found him later in a shed. He said he wanted to be with his brother. His brother used to be a resident here. I am not sure when his brother was moved to a different facility. I asked him where he was going and he just said, 'I had to go, I had to go'. I called the CNA supervisor earlier to let her know (R2) was exit seeking and I physically went to the nurse's station and told them (R2) was trying to get out of the building. Then a few hours later he did just that and got out of the building.</p> <p>The Facility did not provide any statement from V7 regarding R2 eloping and/or attempting to elope on 6/10/2025. No statement was provided, and all statements were requested.</p> <p>On 6/12/2025 at 5:19 AM, V8, Certified Nursing Assistant (CNA) Supervisor stated, (R2) got out the 400-hall smoke door. I found him in the shed when we were looking for him and brought him back. (V7) had notified me earlier that he was pacing back and forth and was wanting to go out towards the door. (V7) saw him leave and she followed him the whole time. He was hiding in the shed. I went and got him and brought him back in. This happened during shift change. Once we brought him back into the building then we put him R2 on a one on one. I asked where he was going, and he said he missed his brother. His brother used to be a resident here too. I did not call or notify the police when he went missing. He was missing for about 15 minutes, but staff had eyes on him at all times.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A statement by V8 dated 6/10/2025 documents, To whom it may concern, I arrive at work about 5:40 AM, same in the AM on June 10, 2025, about 6:20 AM, CNA let me know (R2) ran out back doors, staff went after him when he came out the front door running towards the parking lot, came around the building and I saw something by the shed, so I told the CNA's to come assist me and (R2) was in the shed building hiding behind mattress. Brung [sic] resident back to the facility put him on 1:1 till EMT (emergency medical team) arrived.</p> <p>An additional statement by V8 dated 6/19/2025 at 8:08 AM, document, She (V7, CNA) did text me and told me he (R2) was trying to get out. Arrived at building at 5:40 AM. Did rounds, Posted staffing. I was almost at 300 nurse's station when I heard he had got out. (V7) did not contact me at 2:00 AM.</p> <p>On 6/18/2025 at 1:42 PM, V19, CNA stated, (R2) has a history of trying to leave the facility and is exit seeking. (R2) used to be on the bottom floor and would try and crawl out the window, that is why they moved him to the upper floor. He is in the elopement book.</p> <p>On 6/18/2025 at 1:43 PM, R2 stated he did leave the facility, but he was looking for deer, he likes to deer hunt. When asked if he was deer hunting that day R2 replied yes, he was deer hunting and had his gun.</p> <p>On 6/20/2025 at 4:14 PM, V10, Regional Nurse Consultant stated, (V7) did not notify management (V8) that (R2) was exit seeking but (V8) did not get a call until after 4:00 AM. V10 also stated she would expect staff to follow policy and if a resident was exit seeking, she would expect management including the Administrator to be notified right away if they were exit seeking.</p> <p>On 6/12/2025 at 5:52 AM, review of the video footage shows the following, R2 came out of his room at 5:49 AM, sat in a chair next to door, (smoking door) exited the door at 5:51 AM, two staff ran after him and then at 6:05 AM, staff brought him back inside the facility. The camera only shows him leaving the facility and returning. No video footage was available to review once R2 was outside of the facility. The video shows R2 returning to the facility surrounded by multiple staff at 6:05 AM. Per the video footage R2 was gone for 15 minutes.</p> <p>On 6/12/2025 at 5:54 AM, the shed is really a metal cargo container which was located on the facility property. The metal cargo container has a door on the side of it, inside are stacked used mattresses, about five of them, old luggage, doors (around 10 wooden doors standing upright), spiders, mouse droppings, and lots of boxes crammed into a small space. The door was locked and had to be opened with the Maintenance Director.</p> <p>On 6/12/2025 at 5:58 AM, V10, Regional Nurse Consultant (RNC) stated (R2) was found in the metal cargo container that staff are referring to as the shed. I am not sure why the door was not locked or how he got in it.</p> <p>On 6/18/2025 at 10:24 AM, V35, Psychiatrist stated he did not have his records/chart in front of him for (R2). V35 stated from what he could remember R2 was admitted to the psych hospital because he was agitated and paranoid. He remembers he did try to elope from the nursing home. V35 stated he does not remember R2 being guarded, and he was alert x 3. V35 stated R2 knew he was at the hospital and R2 was redirectable. V35 stated he does not feel he had any issues with safety awareness and could navigate safely, but he was paranoid.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 6/25/2025 at 3:54 PM, V40, CNA stated I was at the nurse's station the day (R2) eloped. I had just done a round, and I went to nurses' station and saw (R2) sitting next to the door, next thing I know (R2) bolted out the door, the alarm was going off and I remember running after him. (R2) was running and he was running fast. I did lose sight of him, but other staff were searching the area and they did find him in the red shed.</p> <p>Statement from V40 dated 6/10/2025 documents, Today, I was at the nurse's station getting a drink when a CNA yelled, 'He's running out'. Myself and other CNA tried to chase him but couldn't catch him. We later found him in a shed.</p> <p>On 6/12/2025 at 4:39 AM, V41, CNA stated she was not aware of any resident eloping from the facility in the last 30 days.</p> <p>Statement from V41, Certified Nursing Aid dated 6/10/2025 documents, I saw a resident run out (R2) of the door. I proceeded to chase him along with several others. I looked around for him, found him hiding in the shed.</p> <p>Statement from V27 dietary undated documents, When I got to work, I heard a lot of yelling I came out the back door and saw (R2) by the shed, but I didn't walk up on him cause (V8) was already there.</p> <p>Statement not legible and undated documents, I was charting when I heard the door alarm go off, I heard the aids say (R2) was running out the back door. I ran out the front door to see if I could see him. We looked around and found him.</p> <p>R2's EMS (Emergency Medical Services) report dated 6/10/2025 at 8:04 AM, EMS dispatched to (facility) for a [AGE] year-old male with behavioral and elopement issues. Upon arrival nurse gave a brief report stating the patient is alert x 4. The patient has a history of paranoid schizophrenia, HTN (High blood pressure) and anemia. Upon arrival patient was found standing in the hallway and initial assessment was done and patient was found to be alert and orientated x 4. Patient self-walked to the cot where he was then secured to the cot with the safety belt and side rails. Once in the ambulance a second set of vitals were obtained as well as a signature from the patient.</p> <p>R2's Hospital Record dated 6/10/2025 at 8:37 AM, document, [AGE] year-old male history of dementia, schizophrenia, who was brought to the emergency room from a psychiatric facility for psychiatric evaluation. Patient is poor historian; all information was obtained from EMS per facility report. Patient, per report, has been agitated, had multiple attempts this week to elope, patient denies any suicidal or homicidal ideation, being compliant with his medications. Patient is alert and orientated x 2, his judgement and insight are limited. He is paranoid and guarded. He is irritable and labile. Certified Medical Emergency, Patient's condition represents a Certified Medical Emergency. Hospitalization required. Diagnosis dementia in other diseases classified elsewhere with behavioral disturbances.</p> <p>R2's Hospital Psych Discharge Notes dated 6/16/2025 documents, Reason for admission and hospital course. Patient was a resident at the nursing home. He was sent to the hospital because of increased paranoia and agitated behavior. Patient was admitted to the closed psych unit. He was started on medication. His medications were adjusted. He was provided educations, supportive therapy.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Facility Elopement Policy with a review date of 9/2022 documents, 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. This does not include alert and oriented residents who handle themselves outside the facility and choose to leave the facility, even if against medical advice. While presenting different care challenges, these alert residents are not in the same category of potential danger as the residents with impaired cognition trying to leave the facility, and their absences from the facility are not considered to be an elopement.</p> <p>The Immediate Jeopardy that began on 6/10/25 was removed on 6/23/25 when the facility took the following actions to remove the immediacy:</p> <p>1. Identification of Residents Affected or Likely to be Affected:</p> <p>The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. Completion Date: 6/23/25</p> <p>-V10, Regional Nurse Consultant, RNC, in-serviced V2, DON, and V1, Administrator on elopement policy 6/20/25.</p> <p>-V2, DON/Designees to provide in-serving on elopement policy to all staff prior to the start of their next shift. Ongoing.</p> <p>-All residents were reassessed by the clinical leadership team, using the Elopement Risk Assessment Tool completed 6/20/25.</p> <p>-All residents identified as at risk for elopements have had their care plans reviewed by the MDS nurses, V28, LPN, and V29, LPN, for resident specific interventions. Completed 6/23/25.</p> <p>-The elopement binder was reviewed by the V10, Regional Nurse Consultant, to ensure those residents at risk for elopement, have a face sheet and picture in the binder. Completed 6/23/25.</p> <p>-V2, DON/Designee will in-service CNAs on reviewing of individual service plans of residents prior to their next shift. Ongoing.</p> <p>2. Actions to Prevent Occurrence/Recurrence:</p> <p>The facility took the following actions to prevent an adverse outcome from reoccurring. Completion Date: 6/23/25</p> <p>-The DON/designee, V2, will in-service staff on facility elopement policy once a month for the next 3 months. Started on 6/20/25.</p> <p>-The DON/designee, V2, will audit new admissions daily to ensure the Elopement Assessment Tool has been completed and that risk factors, safety measures, and resident specific interventions are reflected on the care plan as well as updated on the individualized service plan. It was initiated on 6/20/25 but there have been no admits.</p> <p>(continued on next page)</p>		

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