STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nexus Pavilion at Belleville	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.This failure resulted in an Immediate Jeopardy, which was identified to have begun on 7/25/25 when the R7 eloped from the facility. V1, Administrator, V2, Director of Nursing (DON), V3, Regional Nurse Consultant (RNC), and V19, Regional Director of Clinical and Operations, were notified of the Immediate Jeopardy on 7/30/25 at 4:08 PM. The surveyor confirmed by interviews, observations, and record review, the Immediate Jeopardy was removed on 8/1/25, but the noncompliance remails at Level Two due to additional time needed to evaluate implementation and effectiveness of training.The Findings Include:R7's admission Record, dated 7/28/25, documents R7 was admitted to the facility on [DATE] 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 [DATE], 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), 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 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