STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145613	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Cahokia	3354 Jerome Lane Cahokia, IL 62206

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 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.The Immediate Jeopardy began on 8/13/25 at 2:38 AM when R5, a confused resident, exited the facility unsupervised and was found 1.2 miles away. R5 returned back to the facility with staff at 3:36 AM. On 8/19/25 at 9:03 AM, V1 (Administrator) was notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 8/20/25. Findings include:R5's Face Sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, epilepsy, moderate protein-calorie malnutrition, cannabis abuse and schizophrenia.R5's Minimum Data Set (MDS) dated [DATE], 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: 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 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

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation the facility failed to assist with financial matters for 1 out of 1 residents (R2) reviewed for social services in the sample of 8. Findings include:R2's Face Sheet documented he was admitted to the facility on [DATE] with diagnoses of, in part, metabolic encephalopathy, type two diabetes mellitus, artificial left eye, lack of coordination, dementia, and cognitive communication deficit.R2's Minimum Data Set (MDS) dated [DATE] documented he was moderately cognitively impaired and required supervision or touching assistance with transfers and ambulation. R2's Care Plan dated 6/2/25 documented he required assistance with daily care needs related to safety concerns and has impaired vision related to his left eye prosthesis.On 8/14/25 at 11:45 AM, R2 could not answer appropriately when asked if he every goes to the bank or if he wanted to close his bank account out. R2 could not recall going to the bank.On 8/19/25 at 12:15 PM, V1, Administrator, stated R2 had recently gone out to the bank and the teller called us and said she was going to call us into the state. V1 stated R2 was brought to the bank by V15, Medical Records, and V17, Transportation, to get R2's bank statements. V1 stated R2 needed to get his bank statements because of a Medicaid Spend Down issue. V1 stated it was discovered during R2's redetermination that he had too much money in his account for Medicaid to enroll him. V1 stated R2's bank account statements were needed for this process in order for R2 to be eligible for Medicaid. On 8/19/25 at 12:24 PM, V16, Regional Business of Manager, stated the State of Illinois was needing R2's bank account statements for redetermination for Medicaid but he couldn't access his accounts when he went to the bank because he had no identification. V16 stated now we are in the process of getting him proper identification to be able to get his account information. On 8/19/25 at 12:30 PM, V15, Medical Record, stated V16 needed R2 to go to the bank. V15 stated she went to R2's room and explained everything that was going on and what was needed. V15 stated V17 was the one who took R2 to the bank. V15 stated while R2 was at the bank, the bank teller called her and was concerned about what R2 needed. V15 stated she explained everything about Medicaid and redetermination to the teller over the phone, but she had seemed questionable about what was going on and because R2 didn't have identification, she wasn't able to do anything. V15 stated she's not sure how transportation handles taking residents to the bank, but she thinks if he was alert and ambulating then he went in by himself but V15 went in soon after.On 8/19/25 at 12:37 PM, V17, Transportation, stated he took R2 to the bank but wasn't sure why, only that the business office needed him to go. V17 stated he got R2 inside the bank with the teller and then waited in the van until he was flagged down by the teller because R2 couldn't communication or articulate to them what he needed done. V17 stated R2 used his walker to ambulate. V17 stated the bank called V15 for clarification but they were not able to complete anything due to R2 not having proper identification on him. On 8/20/25 at 9:50 AM, V1, Administrator, stated she would have expected R2 to be accompanied by a staff member at the bank with providing assistance and assumed that had taken place. The facility's Resident Rights Policy dated 8/1/22 documented the facility strives to consistently and fully comply with the various laws and regulations, including but not limited to the treatment, services and needs of residents to attain or maintain residents' highest practicable physical, mental and psychosocial well-being. The policy continued to document the facility shall safeguard residents' financial affairs.