STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0054841**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	**6800 WEST JOLIET , INDIAN HEAD PARK, Illinois, 60525**

(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 1016023 / IL196143 1016043/ IL196238	S0000		08/13/2025
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 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 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	S9999		08/13/2025

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

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S9999	Continued from page 1 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 EVIDENCED BY: Based on interview and record review, the facility failed to secure the physical environment (window) in R1's room and implement appropriate precautions for a resident with a history of elopement risk, high suicidal risk, high risk per criminal background/ behavioral history, and assessed as being unsafe in the community unsupervised for one resident (R1) of three residents reviewed for elopement. This failure resulted in R1 removing the stationary window brackets that prevent the window from opening in his room, jumping out of the window, and eloping through the open back gate of the facility undetected by staff. Findings include: R1 is a 28 year old resident with diagnoses that include Bipolar Disorder Severe with Psychotic Features, Delusional Disorder, Suicidal Ideation, Suicide Attempt, Major Depressive Disorder, Psychosis, Schizoaffective Disorder, Violent Behavior, and Attention Deficit Hyperactivity Disorder. On 7/9/25 at 9:49 AM, V5 Family Member was inquired of	S9999		

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S9999	Continued from page 2 R1. V5 said, "I was told R1 unscrewed the window screws with a fork and jumped out the window of his room on 7/3/25 during the night. I was notified later that night. R1 hasn't been found. R1 sent a text message to his father and I from different phones saying he wants to die. He won't go to the hospital or tell us his location. He wants to care for himself. He has Bipolar with Schizoaffective Disorder. He tried to commit suicide before in jail, he jumped headfirst from the balcony. On 7/9/25 at 10:45 AM, upon observation R1's room is locked when attempting to enter. V6 Maintenance Director arrived to open the room for this surveyor. V6 said, "It's a one person room so since R1's things are here I just locked it." R1 has a private room three doors from the nurse's station. Upon entrance to the room, it appears to be organized, there are food items, R1's identification card, and phone charger are on the bed. There are 2-3 bags of clothing stacked up in the left corner in a laundry basket. There is one large window with 3 windowpanes facing the back of the facility. V6 moved the center windowpane into the open position it was in when he arrived in the room after R1's elopement. V6 said, "I came in on the of July 4th day shift. His room was a wreck. His clothes and food were all over the floor. The middle window was open and slide to the right. This part of the window isn't supposed to open, it's stationary. R1 broke the stoppers off the window." Upon observation, the window screws at the top are bent and V6 opened the middle windowpane and slide it over to the right as it was when he found it. The middle windowpane appears to have been dislodged from the window frame from the top allowing it to become unsecured and opened. On 7/9/25 at 11:08 AM, V6 escorted this surveyor to the backyard area of the facility. Upon entrance to the backyard there is a wooden fence that is secured by a lock that was opened by V6. There are 2 cameras on the back of the building facing the yard area. Under R1's window are pieces of a broken fence on the ground. There is a basement level window beneath R1's first floor window. V6 measured the space from R1's window to the ground which measured a 9-10 foot drop from the 1st story window. The wooden fence was observed to be intact. There is another gate entrance on the east side that is not secured. V6 said, "R1 must have jumped the fence." On 7/9/25 at 11:24 AM, V7 RN Registered Nurse was inquired of R1. V7 said, "R1 always isolates himself.	S9999		

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S9999	Continued from page 3 If I ask how he is, he can't answer correctly. He'll say something off the topic. R1 did get out the building before. I had an instance when a CNA (Certified Nurse Assistant) opened the ramp door for a family member, and he ran in front of them into the parking lot. We got him back in. He only had a day pass if the family requested, and they had to pick him up here. I came in on July 4th 7AM to 3PM shift. I was told in report R1 eloped on 3PM to 11PM shift, they looked for him and called the police. On 7/9/25 at 11:50 AM, V9 Restorative CNA said, "I was here on July 3rd, on 3PM to 11PM shift. I came by to get the linen bin by his room and his door and window was open. I checked the bathroom, and he was gone. I ran to the nurse's station and called a code pink. Staff went outside and police were called. I didn't see anything on the windowsill. I saw him last around 10:15 PM just in his room." On 7/9/25 at 12:22 PM, V11 CNA was inquired of R1. V11 said, ""I worked 3PM to 11PM. R1 is quiet and stays to himself. I checked on him during rounds and mealtimes. He ate his own food in his room. Closer to the end of the shift V9 CNA and I peeked in his room, and he was gone. We checked his bathroom. The middle part of the window was open. I didn't notice anything else. We called a code pink. The nurse called 911, staff searched and drove around to see if he was in the area. It was close to 11PM when police came." On 7/9/25 at 12:45 PM, V3 DON Director of Nursing was inquired of R1's elopement being notified to Illinois Department of Public Health. V3 said, "We didn't report it because he's been in contact with his family via phone and we don't have knowledge of him being injured or hurt." On 7/9/25 at 12:55 PM, V12 RN Registered Nurse said, "I was the nurse on first floor on July 3rd 3PM to 11PM shift. R1 hangs out in his room. He's a smoker. That night I did my rounds. He took his medication. I saw him last around 10 PM. He was in his room sitting on the bed. V9 CNA came to me at the nurse's station around 10:30 PM. She said she was doing her rounds and didn't see R1 in his room. I got up, went to his room, looked, and called his name. I checked the bathroom and the room and saw the middle of the window was open. I called a code pink. Staff came down and went outside the building. I called 911, the administrator, director of nursing, and the family. I went back into the room; I didn't see anything on the windowsill. I looked out the window and saw a part of a fence on the ground. I didn't hear anything."	S9999		

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S9999	Continued from page 4 On 7/9/2025 at 1:30 PM, V13 PRSC Psychiatric Rehab Services Coordinator was inquired of R1. V13 said, "I was R1's social worker. I worked July 3rd till 4:30 PM. R1 is very anxious, and he paces. It's his baseline behavior. He was quieter that day, he didn't come into my office. He usually comes in every day. His diagnoses are Bipolar Schizoaffective Disorder, Schizophrenia, Delusional Disorder, Hallucinations, Anxiety, and Depression. He only has community access with family if he's compliant with medication. He's never had an independent pass. His last community survival assessment was on 5/1/25, it says he has behavioral concerns and elopement. I spoke with him on July 2nd, he came to my office with some books and talked about things that didn't make sense. His delusions were mixing with reality. But it was getting harder for me to understand what he was talking about. This week I was trying really hard to understand. He was someone we'd keep an eye on more and look through his things. We'd take things so he's safe. He's an identified offender because of his charge of aggravated battery and bodily harm. He was sent out on petition on June 10th to the hospital because of his behavior, but I wasn't aware he got out the building. I feel his behaviors built up." On 7/9/25 at 2:15 PM, R5 was inquired of R1. R5 said, "R1 was very anxious. He was just talking to himself before he left and was pacing. It startled me. A couple of days before we were in the basement, and he took a fork and showed me how to pry open the door and escape. He asked me if I wanted to escape, and I said I wasn't going to do it. I saw him last at smoke break around 6PM. He must have got out before 11PM because he usually meets me by the vending machine at night to get snacks. He texted me the night after he escaped. I tried to call him back, but his phone was off." On 7/14/25 at 12:29 PM, V3 DON Director of Nursing was inquired of R1's elopement. V3 said, "I got a call from the assistant director of nursing maybe 10:45 PM on July 3rd. Assistant Director of Nursing called me, and V12 RN notified me and said R1 was missing. V9 CNA checked his room and noticed the window was out. They initiated a code pink; they did a facility search and checked all exit door which were secured. Staff went out on the grounds to look for him. The police were called, they arrived at the facility before midnight. They took a report and gave the report number to the ADON. The doctor, family and administrator were notified. Change of shift was reported that R1 was missing, and I asked them to call local hospitals and be on standby if he comes back. He has gotten out	S9999		

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S9999	Continued from page 5 before. He pushed out the front door and staff was behind him. He walked down the road, and we called the police to redirect him back to the facility. He was petitioned back to the hospital for a psychiatric evaluation. The psychiatrist did a medication adjustment for him. Elopement risk assessment done, he got out, but staff was behind him. He was placed on a one to one supervision until he was transferred to the hospital. We sent him out for another hospital psychiatric evaluation. He has a history of suicidal ideation. Prior to coming to this facility, he had a suicidal attempt in the hospital. When he initially came, he was identified as an extreme offender on his background check. It was recommended from his criminal background to be placed in a private room due to his history of suicidal attempt with jumping out of a third story window prior to his admission. Our administration decided it would be safer for him to be on the 1st floor opposed to the higher floor being more potentially dangerous. He is just supervised and encouraged about medication compliance. During the investigation, we didn't find any utensils, a room search was done, and nothing was found. R1 was found in a hospital in Wisconsin on yesterday and was checked medically and deemed safe with no medical issues. Due to their state regulations, they were unable to admit him to inpatient psychiatric care. R1 was transferred back to this facility via ambulance yesterday evening and staff notified his physician. He was transferred to the hospital for psychiatric evaluation." On 7/14/2025 at 1:05 PM, V1 Administrator was inquired of R1's elopement. V1 said, "V28 ADON called me during the night around 10:30 PM. They said the window was out in his room. The staff called a code pink that went and searched the building and outside in the back and around the area. They went to 7-11 store but didn't see him. Police were called. Police did a missing person report for all the surrounding cities. We started calling local hospitals, but he didn't show up. We called the doctor and family. His mom or dad said he uploaded an Instagram picture, but we couldn't locate him. He got out before but didn't make it far. In June got out the front door behind a visitor, but staff went out behind him. He hasn't gotten aggressive since being here. His criminal history showed he has aggression and needed a private room. We did have to call the police and they brought him back and we petitioned him out the hospital for psych evaluation. He's not exit seeking usually, it just happened. His room is by the nurse's station. We didn't put him on 3rd floor, but due to his history we put him on 1st floor due to him jumping from windows. We didn't find anything. We have cameras and saw him tumble out the window, he got up and walked	S9999		

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S9999	Continued from page 6 away fast. He walked toward the 7-11 store. The staff went over there but didn't find him. We checked the camera and it showed R1's legs and he rolled out the window, got up and walked fast to the other side of the yard and went out the gate." On 7/14/25 at 1:42 PM, V3 DON was inquired of security and cameras. V3 said, "The last smoke break time is between 6-7PM. Residents with an independent pass have to be back in the building by 7:30 PM. They can go in and out of the back gate, it's not locked. We have staff monitor it. The security cameras are in V1's (Administrator) office and she's the only person with access. We don't have security." On 7/15/25 at 2:26 PM, V14 PRSC Psychiatric Rehab Services Coordinator was inquired of R1's 6/18/25 elopement risk review decision score. V14 said, "The elopement risk is triggered within the first 24hrs when a resident comes in. Sometimes nurses will complete it. It's a part of the admission documents. Social Service staff should review the elopement risk and correct it if it's not right. It's especially important for R1 because he is high risk for elopement. We know he's not a low risk elopement taking account his history." On 7/16/25 at 10:40 AM, V6 Maintenance Director was inquired of R1's window in the room. This surveyor and two other survey staff reviewed R1's room window with V6 Maintenance Director. V6 said, "I don't know how he would have gotten the window open with his hands. He must have used something to get it open because the brackets to keep the window from opening were broken. I added bolts to reinforce the window and L bracket to prevent it from being pulled back." On 7/14/25 at 9:50 AM, V3 DON was inquired of R1's status. V3 said, " R1 was found in a hospital in Wisconsin diagnosed with altered mental status then transferred back to the facility. R1 was evaluated and ordered to be sent out for psychiatric evaluation at the local hospital. On 7/14/25 at 1:30 PM, V1 Administrator and this surveyor viewed the security camera footage from July 3, 2025, at 10:28 PM. The camera showed R1 jump from his window to the ground, rolled once and stood up. R1 walked quickly toward the east side of the back yard on the sidewalk through the open gate. V1 Administrator was inquired of the east gate being left open. V1 said, "The gate is usually left open for the residents that have an independent pass. The residents come and go from that gate and sit in the yard area."	S9999		

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S9999	Continued from page 7 On 7/24/25 at 9:53 AM, V3 DON Director of Nursing was inquired of R1's involuntary discharge. V3 said, "Due to his high elopement risk he was deemed not fit for the facility. He may need a different environment. He was bored here. He's younger. The population wasn't conducive for him along with his diagnosis and extreme exiting desire. We provided all the services he needed, but he spoke with his mom and said he was bored here. He wants to be free and work. He just wanted to be outside. It was an interdisciplinary decision with his physician and R1. His family lives out of state and the facilities there are not up to their standards so R1 was accepted into a facility in Waukegan. He agreed to go. R1 could potentially lure or coax other residents to elope or help them elope. He wasn't appropriate for this facility; he was a safety risk. R1 was hand delivered a petition at the hospital with a stamped envelope. He was explained the appeal process, and his family was notified. We'll coordinate with the other facility to transfer his belongings. The facility will have to do a medical request for pertinent information, and it will be sent from medical records." R1's records were reviewed as follows. R1's progress notes from 6/10/25 at 11:30 AM document being discharged to the hospital. R1 is delusional, hallucinating and paranoid. Unable to take vital signs, patient is refusing. 911 called. R1's physician ordered him to be sent to the hospital for a psychiatric evaluation. On 6/10/25 V14 PSRAD Psychiatric Rehab Services Assistant Director completed a petition for R1 to be hospitalized. R1 eloped out of the front door of the facility pushing past visitors leaving the grounds. The facility required police intervention to transfer R1 to the hospital for psychiatric evaluation. R1 was hospitalized for six days. R1 returned to the facility 6/16/25. On 6/16/25 V20 NP Nurse Practitioner documented R1 was hospitalized for Psychosis. Hospital reports states patient presented to the hospital via EMS (Emergency Medical Services) after eloping from a nursing home and being found trespassing behind a dumpster smoking marijuana. On 6/18/25 at 20:53 (8:53 PM) R1 was evaluated by V21 Nurse Practitioner Psychiatrist following his hospitalization. Assessment- this patient has multiple psychiatric complexities and would benefit from continued management with monitoring of mood and behavior. Will titrate medications based on current	S9999		

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S9999	Continued from page 8 symptom progression. The 6/18/25 elopement risk review documents: 2. elopement history/community risk- reported/documented episodes of elopement and/or attempts to elope: 2. no. Total score: 23 low risk. On 7/15/25 at 2:26 PM, V14 PRSAD Psychiatric Rehab Services Assistant Director was inquired of R1's 6/18/25 elopement risk review decision score. V14 said, "The elopement risk is triggered within the first 24hrs when a resident comes in. Sometimes nurses will complete it. It's a part of the admission documents. Social Service staff should review the elopement risk and correct it if it's not right. It's especially important for R1 because he is high risk for elopement. We know he's not a low risk elopement taking account his history." R1's June 2025 and July 2025 behavior monitoring from his 6/16/25 readmission to 7/3/25 does not document any identified behaviors. R1's July 2025 MAR (Medication Administration Record) documents he received Depakote ER (extended release) oral tablet 250mg (milligrams) give 3 tablets by mouth at bedtime for Schizoaffective Disorder on 7/3/25 at 2100. R1's progress note states: 7/3/25 at 23:20 (11:20 PM), V12 RN Registered Nurse documented at 10:30PM, CNA Certified Nurse Assistant observed resident sitting in his room. At approximately 10:35 PM, CNA walked past resident's room and noted his window was open and he was no longer present. Upon further inspection, it was discovered that part of the window had been removed. A code pink was immediately called. All exit doors were secured, and staff completed a search of the facility and grounds The Administrator, DON, Social Services, MD, and resident's mother was notified. Monitoring and communication with local hospitals, police, and emergency services are ongoing. On 7/4/25 at 12:26 AM, the police department official report documents the police response to the facility for a missing person R1. R1's 5/1/25 community survival skills assessment recommendations indicate resident has supervised community access due to behavioral concerns as well as history of elopement. The care plan documents an updated 6/18/25 assessment but is not found in R1 records upon his readmission to the facility. R1's 2/20/24 criminal history record indicates aggravated	S9999		

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S9999	Continued from page 9 battery and bodily harm. R1's care plan documents the following: Elopement Risk I, R1, am challenged by mental illness and poor insight. I have a history of leaving my former facility without notifying staff and having a responsible escort (elopement). I also have a history of wandering into restricted and/or dangerous places. I will respond to staff direction to redirect his attention away from a potentially problematic situation (i.e. trying to exit the facility without supervision) when this behavior occurs. Interventions: Elopement Risk assessment completed per policy. • Implement "preventive" intervention strategies that include: ÿî Assess me for potential elopement/unauthorized departure risk. ÿî Make rounds/room checks per facility protocol to minimize chance of unauthorized leave. • Implement Elopement Risk Protocol • Redirect resident to room/unit• Use distraction to try to distract resident away from the current situation. Suicidal Risk: I, R1, have a history of suicidal ideations and attempts related to mental illness. I deny current S/I or intent. My self-identified triggers include medication noncompliance and using illicit substances. Interventions: As warranted conduct/carry out: Daily monitoring & supervision of the resident. SMI Severe Mental Illness: The resident has a diagnosis & history of severe mental illness (SMI) of Bipolar, Schizoaffective & Depression. The resident will: take medication as prescribed. Interventions: Explain facility rules, resident behavioral expectations & resident rights. R1 requires psychotropic medication to help manage and alleviate: Bipolar, SA Schizoaffective Disorder, SI Suicidal Ideation, AH Auditory Hallucination, Psychosis, Delusions, Agitation and Aggressive Behavior, ADHD Attention Deficit Hyperactivity Disorder, Depression, Behavior with Depressive Features, Anxiety, Neurosis. Aggression Risk: I, R1, am challenged by mental illness, mania, and psychosis. I am noted to respond/react to internal stimuli. Symptoms are manifested by aggression when agitated. Behavior: The resident expresses maladaptive behavioral symptoms related to: A diagnosis of chronic mental illness, a substance abuse disorder. R1 has presented with using the utensils that are provided at mealtime, to barricade himself in his room.	S9999		

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(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 10 Due to R1's h/o suicidal ideation this behavior poses a risk to his safety. R1 is to be provided with plastic silverware only. R1 is given plastic silverware to prevent him from barricading himself in the room. Isolating: The resident expresses maladaptive behavioral symptoms related to isolating himself in his room. Intervention: Involve the resident to supportive incidental, group or 1:1 counseling, as appropriate. Indicate treatment modality. Community Access: I, R1, do not appear to be capable of unsupervised outside pass privileges at this time. I require support and supervision in order to safely access the community independently rt: mental health needs. Intervention: Conduct a "community survival skills assessment" or similar community safety evaluation to reasonably the person's ability to safely determine and respectfully negotiate within the outside community. Initiated 6/18/25. No assessment dated 6/18/25 found in R1's documents. R1's comprehensive assessment section C cognitive patterns dated 5/7/2025 documents a brief interview for mental status score of 14. R1 is cognitively intact. R1's comprehensive assessment section E behavior dated 5/7/25 does not document any behaviors despite V13 PRSC's concern of R1's delusions prior to his elopement during interview on 7/9/25. R1's comprehensive assessment section GG functional abilities dated 5/7/25 documents he required supervision or touching assistance (helper provides verbal cues and/or touching/steading and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. The following activities are documented: toileting hygiene, shower/bathing, personal hygiene, sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, walking 10 feet, 50 feet with two turns, and 150 feet. R1's 7/13/25 hospital records document a referring diagnosis of Schizoaffective disorder (a mental illness characterized by psychotic symptoms of hallucinations and delusions plus significant mood disturbances (mania or depression)). R1 presented to the emergency department for increased mania and eloping from a nursing facility to Wisconsin. R1 stated, "I just wanted to leave for a while." He is internally preoccupied. Patient is in need of inpatient psychiatric hospitalization for mood stabilization and safety.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054841	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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S9999	Continued from page 11 Visit diagnoses include Compulsive behavior, Bipolar affective disorder, current episode manic (a period of abnormally elevated or irritable mood, increased energy, and activity levels, often associated with bipolar disorder. Schizoaffective disorder. R1's mental status exam documents: patient's grooming and hygiene is poor. Thought content: Auditory hallucinations are present. Delusions and paranoia are present. Insight/Judgment: poor. This patient is admitted to the hospital for stabilization of acute psychiatric issues. Will titrate medications and provide psychotherapeutic services on the unit and within the milieu in order to improve decompensated symptoms. R1 received prescribed medications for stabilization and remained hospitalized. On 7/15/25 at 3:59 PM, V21 NP Nurse Practitioner documented on R1 during his hospitalization: Late Entry: Facility cannot meet the resident's requirements due to extreme psychiatric needs. He is an elopement risk. Presently patient is a threat to himself and others and is not appropriate to remain at Briar Place. Involuntary discharge requested. On 7/17/25 at 11:35 AM, V14 Psychiatric Rehab Services Assistant Director documented on R1 during his hospitalization: Social Service Note: On this date, Ryan was reserved with IVD due to error on previous form. Attached with IVD was bed hold policy and stamped and addressed envelope. Social worker Abby present at the time of drop off. Ryan was told how to appeal and the process. Ryan expressed his understanding had no concerns. The revised 1/25 Policy and Procedure Missing Resident states in part: It is the policy of this facility to report and investigate all reports of missing residents. Procedure: 1. All personnel are responsible for reporting a resident attempting to leave the premises, or suspected of missing, to the charge nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving. 3. Should an employee discover that a resident is missing from the facility, he or she should: f. The Administrator and Director of Nursing will evaluate the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054841	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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S9999	Continued from page 12 situation and develop a plan of action based on the individual resident. The following steps should occur: 11. The decision to notify the Illinois Department of Public Health is made by the Administrator. a. The Illinois Department of Public Health is notified after the confused/disoriented resident is missing for 24 hours and all attempts to locate the resident have been exhausted. - This notification does not include the resident who is alert/oriented and has made a decision to leave the facility and not return. (A)	S9999		