WHE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 3334 JEROME LANE CAHOKIA 3334 JEROME LANE CAHOKIA, IL 62205 DUID PRETX TAG Issummary STATEMENT OF DEFICIENCISS (RECHORDER) PLANOF CORRECTION (RECHORDER) STATE (PERCEDED STULL, IL RECULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG S 000 Initial Comments S 000 Complaint Investigation: 2446057/lL176227 S 000 S 100 Complaint Investigation: 2446057/lL176227 2446082/lL176266 S9999 S 001 Sold Table Stream of the productions: 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 be followed in operating the facility shall provide the necessary care and services to athal the relived in aperating the facility shall provide the necessary care and advisory committee consisting and Other acting and Personal Care Nursing and Other assidue to shall be governing and envices to athal or mainters for Nursing and Personal Care b). The facility shall provide the necessary care and pervices to athal, and psychological well-being of the resident, in accordance with each resident or maintain the highest practicable physicat, mental, and psychological well-being of the resident. 3) All nursing personnel shall assist and encourage residents 0) All nursing personnel shall assist and encourage residents	Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORPECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
ILEGO7983 B. WING OB/20/202 WALE OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE 3364 JEROME LANE CAHOKIA 3364 JEROME LANE CAHOKIA CAHOKIA CAHOKIA, ILE 62206	ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
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automation Complaint Investigation: 2446082/IL 176227 2446082/IL 176266 \$9999 Final Observations \$9999 Statement of Licensure Violations: 300.610a) 300.1210b3)4) \$9999 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 provided to each resident's comprehensive resident care plan. Adequate and properly supervised nursing care needs of the resident. a) All nursing personnel shall assist and encourage residents so that a resident who is	PRÉFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
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	r c	Nursing and Person o) The facility shall and services to atta practicable physica vell-being of the re each resident's cor plan. Adequate and care and personal of esident to meet the care needs of the r 3) All nursing p	nal Care I provide the necessary care ain or maintain the highest al, mental, and psychological esident, in accordance with mprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal resident.				
Electronically Signed 08/2	ORATORY D	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE 08/23/24

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	or connection	IDENTIFICATION NOMIDER.	A. BUILDING:				
		IL6007983	B. WING			C 20/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
BRIA OF	САНОКІА		ROME LANE A, IL 62206				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
S9999	Continued From pa	ge 1	S9999				
	appropriate treatment urinary tract infection normal bladder func- personnel shall ass who enters the facil catheter is not cathe- clinical condition de catheterization was 4) All nursing per encourage resident in activities of daily circumstances of the demonstrate that di This includes the re- dress, and groom; the eat; and use speec functional communi- who is unable to can shall receive the se						
		NT is not met as evidenced by	:				
	review, the facility fa incontinent care to reviewed for ADL (A in the sample of 13	, observation and record ailed to provide timely 3 of 5 residents (R2, R3, R4) Activities of Daily Living) care . This failure resulted in R2 Il harm, making her feel sad					
	Findings include:						
	1. On 8/2/24 at 9:45	5 AM, R2 up in her electric					

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COM	E SURVEY PLETED
		IL6007983	B. WING			20/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BRIA OF	CAHOKIA		ROME LANE A, IL 62206			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	knee. R2 stated the date, she had 3 boy incontinence brief to took the therapist to cleaned up so she she was independed her leg amputated a staff for care. R2 st she can to help the they aren't doing it she had skin break feces. R2 stated th never be mad or qu okay if she just didu R2's Face Sheet, up the following diagno	left leg amputated above the e other day, unsure of exact wel movements in the same before the staff changed her, it o get on them to get her could go to therapy. R2 stated ent with care before she had and is now dependent on the ated she does as much as m when they care for her, so all by themselves. R2 stated down after she was left in her his saddens her and she would be n't wake up. ndated, documents R2 has posis: Need for Assistance with akness and Left Above the	I			
	documents R2 has Mental Status) scor cognitively intact. R and is incontinent c	a Set, MDS, dated 6/28/24, a BIMS (Brief Interview of re of 15, indicating R2 is 2 is dependent with toileting of bowel & bladder. ted 10/25/26, requires				
	assistance with AD	•				
	room in R3's bed. F since 7:30 AM to ge	15 AM, R3 was observed in his R3 stated he has been waiting et cleaned up, he is wet. R3 changed the care is still	5			
	the following diagno	ndated, documents R3 has osis: Metabolic /eakness and Overactive				

	epartment of Public		T			
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
	IL6007983		B. WING		C 08/20/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
BRIA OF	CAHOKIA					
			A, IL 62206	PROVIDER'S PLAN OF (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	BIMS score of 15, in intact. R3 is depend occasionally inconti R3's Care Plan, dat requires assistance 3. On 8/2/24 at 9:30 room in R4's bed. F place a rating of an R4 stated it can tak answered and it's b he has told different isn't dry and put his picking up trays and	O AM, R4 was observed in his R4 stated he would give this "F" for the living environment. the 2 hours to get his call light been like that for 7 months and t people about it. R4 stated he call light on, but the staff are d are busy.				
	the following diagno	ndated, documents R4 has osis: Cerebral Infarction and e with Personal Care.				
	BIMS score of 15, in	/14/24, documents R4 has a ndicating R4 is cognitively substantial/maximal assist ne.				
	R4's Care Plan, dat requires assistance	ted 1/6/24, documents R4 e with ADL needs.				
		AM, V1 (Administrator) stated acontinent care to be provided				
	documents "incontin	re Policy, dated 5/2015, nence care is provided to keep ortable and odor free as				
	"B"					

PRINTED: 09/09/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6007983	B. WING			C 20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BRIA OF	CAHOKIA		ROME LANE IA, IL 62206			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	ment of Public Health					