Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		 	A. BUILDING:			
		IL6007983	B. WING		10/0)2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE			
040.15	CUIMMA DV CTA		A, IL 62206	DDOWDEDIS DI AN OF CODDECT	ON	0.(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Investigation of Fac 9-20-24/IL178581	cility Reported Incident dated				
S9999	Final Observations		S9999			
	Statement of Licens 300.610a) 300.1210b) 300.3210t)	sure Violations:				
	Section 300.610 R	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compl The written policies the facility and shall	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care				
	care and services to practicable physical well-being of the re- each resident's com plan. Adequate and care and personal of resident to meet the	shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each the total nursing and personal				
	tment of Public Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/14/24

Illinois Department of Public Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,			;
		IL6007983	B. WING			2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE , IL 62206			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	care needs of the re	esident.				
	Section 300.3210	General				
	not subjected to ph	shall ensure that residents are ysical, verbal, sexual or e, neglect, exploitation, or property.				
	These requirement by:	s were not met as evidenced				
	review the facility fa are free from sexual (R3, R4) reviewed to of 10. The failure r sexual manner with to trigger memories feelings of fear, wo	on, interview and record alled to ensure that residents all abuse for 2 of 3 residents for sexual abuse in the sample esulted in R4 touching R3 in a rout R3's consent causing R3 of past sexual traumas, rthless, being dirty with 19, and attempting to avoid R4 e facility.				
	The findings include	e:				
	ABUSE: (R3) is at a (related to) hyperte COPD (Chronic Ob Psychosis, anxiety, Schizophrenia. 9/23 received. It continumoved. Assure resund secure environ professionals. Expladjustment is often trusting relationship social worker, nursiverbalizing thoughts	dated 4/1/2024, documents risk for abuse and neglect r/t nsion, hld (Hyperlipidemia), estructive Pulmonary disease), hydrocephalus, and 3-inappropriate behavior es 9/23- res (resident) room ident that he/she is in a safe ment with caring ain that psychosocial facilitated by developing a with another person (i.e., e, CNA, peer) and by s, needs and feelings.				

Illinois Department of Public Health

STATE FORM 6899 GZNY11 If continuation sheet 2 of 11

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
, and the actual control of the cont	BERTH IOTH TOTAL	A. BUILDING:			22.25
	IL6007983	B. WING		I	C 02/2024
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
DDIA OF CALIOVIA	3354 JEF	OME LANE			
BRIA OF CAHOKIA	CAHOKIA	A, IL 62206			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
thoughts, anxieties, feelings. Observe the and insecurity during to calm the resident Review assessment treatment of casual designed to moderate treatment of computabuse, anger, and resident, as in R3's Minimum Data documents that R3. R3's Progress Note PM, documents Numinight of 09/20/2024, and bed of R3) whe According to (R3), (leg and knee, hugget touched her genital (R4) was wearing paraway after (R3) said patient (R4) has been to monitor his behavincidents. (R3) was room 18-1 that she patient stated no sure happened in the faction incident, Psych NP Md (medical doctor). Administrator was in had head to toe dorn complains of pain or noted on head to toe alert and oriented xinting the said to the period of the said to the complains of pain or noted on head to toe alert and oriented xinting the said to the s	dent to verbalize/share fears, concerns, and general ne resident for signs of fear g delivery of care. Take steps t and help him/her feel safe. t information. Emphasize factors and/or interventions ate/reduce symptoms (make alsive behavior, substance mental health issues available indicated). Set (MDS), dated 9/18/2024, is cognitively intact. s, dated 9/23/2024 at 2:29 rese Notes Note Text: On the patient (R4) entered (Room are (R3) was sleeping. (R4), woke her up touched her ed her he then proceeded and area, (R3) told (R4) to stop. ajama pants, he then walked d No. Following this incident, en placed on 1:1 observation vior and prevent further moved to a different hall to had previously requested, ich incident had ever cility, family was notified of the (V6) was made aware, and				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		IL6007983	B. WING			2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE , 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	social to get assistate events. Patient is continues to monitor R3's Progress Noted documents Nurse FAssistant Relevant patient for ongoing continues to have owith current living significant reports that and touched her instant that she initially did afraid of being dismistates that she did Services today. Patient to express hinteractive feedbac While with patient, patient know that she did the patient that she is in and that she did the Patient appeared to different room when more safe. Voiced of patient during a patient toward treat ongoing therapy two R3's Progress Note Relevant Content: ongoing psychother concerns over her live assistant and the patient concerns over her live and the patient concerns over h	ance to dealing with traumatic alm and cooperative. Nurse or patient through the shift." 2, dated 9/23/2024 2:56 PM, Practitioner Narrative/Physician Content: Therapist met with psychotherapy. Patient concerns over her health and ituation. Patient shared with ad been awakened in the at (9/20/24) by a male resident. This resident sat on her bed appropriately. Patient states not report it because she was nissed or invalidated. She report the incident to Social cient shared with therapist how at up past trauma and abuse rapist provided safe space for her feelings as well as and emotional support. (V1) came into the room to let be explored the themes with noncent of any wrongdoing e right thing by speaking out. To be relieved to be moving to a see she voices, she will feel understanding and empathy difficult time and encouraged ment goals. Will continue with	S9999			

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Illinois Department of Public Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		IL6007983	B. WING			2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE , IL 62206			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	adjustment to new managing TV, who change in where sh Therapist allowed from the support and validate Encouraged patientherself with recent in room/roommate. Therapy twice week On 9/23/2024 at 12 was sleep in her rowas awakened by hand on the inside stated that she ask said he was checking stated that R4 then R4 leaned in, hugging vaginal area. R3 stated that she feels dirty showers. R3 stated that this caused he trauma. R3 stated that she feels dirty showers. R3 stated that this caused he trauma. R3 stated that she feels dirty showers in the sees him or tries to stated that she has Disorder) from her brought up all those that she did not was stated that she felt	room/roommate including comes in the room, and a se is allowed to take a shower. For safe expression of feelings atient. Patient and therapist is feelings related to recent uma history that has incident. Continued to be feelings of patient. It to have compassion with incident as well as her change Will continue with ongoing ly. 130 PM R3 stated that she come and at about 11:44 PM she cannot be feelings of patient. It to have compassion with incident as well as her change will continue with ongoing ly. 130 PM R3 stated that she come and at about 11:44 PM she cannot be feel above her knee. R3 led what he was doing and R4 led her, and grabbed her lated that she had on her lated that she had on her lated that she had on her lated that she felt his hand on late. R3 stated that she is afraid. R3 stated and have started taking long that she is afraid. R3 stated and have started taking long that she is afraid. R3 stated and have started taking long that she is afraid. R3 stated and have started taking long that she is afraid. R3 stated and have started to when she stay away from any area. R3 PTSD (Post Traumatic Stress childhood trauma, and this just to be feelings and fears. R3 stated and to be touched by R4. R3 uncomfortable. R3 stated that what is wrong with her that R4	S9999			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		IL6007983	B. WING		1	2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA	3354 JER(CAHOKIA	OME LANE , 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	R4's Care Plan, dat ABUSE: At risk for Schizophrenia. 5/22 inappropriate behave 9/23-inappropriate resident. It continues R4's MDS, dated 8/15 cognitively intact. R4's Progress Noted documents Nurses of 09/20/2024, patient where a female patient's behavior and leg, which caus wake up. R4 then gother patient requeste room. (R4) states the during the encounterpatient on the genit for his actions, statidoes not know why apologized for his was inappropriate. (R4) has been placed monitor his behavior incidents. R4's Physician's Or 9/25/24, documents Ps/25/24, docu	ted 5/31/2023, documents abuse and neglect r/t his Dx of 2/23 Resident was accused of vior with a peer. behavior towards another es 9/23 1 to 1. 2/27/2024, documents that R4 2, dated 9/23/2024 3:35 PM, Notes Note Text: On the night ent (R4) entered (R3's room), itent was sleeping. According into the room late at night while (R4) stated that he sat by the d and noticed that she was ed that he touched her knee sed the female patient (R3) to pave her a hug which he states ed, and afterward, he left the he patient did not say anything er. (R4) denied touching al area. (R4) expressed regreting that he lost control and the acted in that manner. He behavior, acknowledging that it Following this incident, patient ed on 1:1 observation to or and prevent further	\$9999			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		IL6007983	B. WING			2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE , 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	assessment. Staff rentered a female paragraph of the incounseled on the incounseled that he read a different facility wing. Patient endor repercussion. Patient endor repercussion. Patient diagnosed with disorganized schizor On 9/30/2024, at 10 seen, and staff were R4. On 9/30/2024 at 11 knows that he is no rooms. R4 stated the stated that the light somewhere around there was no staff of there is usually stafnight. R4 stated that woke her. R4 stated that woke her. R4 stated that it didn't in happen she said stated that they did therap was attracted to R3 touch R3's genital at touch R3's genital at touch R3's genital at the some said stated that they did therap was attracted to R3 touch R3's genital at the some said sequences.	report that patient recently atient's room and initiated to denied touching her genital her a consensual hug. Patient inpropriety of the situation and may need to be transferred to ith a more separate male sed understanding of possible int continues to deny Sl's/Hl's, anxiety, depression, sleep ditory/visual hallucinations. with paranoid schizophrenia, ophrenia, and MDD. 2:40 AM and 1:15 PM, R4 was e providing 1:1 observation of :08 AM R4 stated that he at supposed to go in the female that he did go in R3's room. R4 was on. R4 stated that it was a 1100, 1130. R4 stated that for the hall. R4 stated that if on the hall, but it wasn't that the went into R3's room and do that he sat on the side of that he hugged R3 and inside of her leg, thigh area old him to stop, and he did. R4 matter what he wanted to op and he did. R4 stated that it buldn't have gone in there, but not at R3 was nice to him and y at the same time, and he as R3 stated that he did not area, he did touch inside her ault that he went into the room	S9999			

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IIIInois D	epartment of Public	Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7110 1 2711	OF CONTRECTION	IDENTIFICATION NONDER.	A. BUILDING:			
		IL6007983	B. WING		10/0) 2/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA	3354 JER	OME LANE			
DIVIA OI		CAHOKIA	, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	Director, stated that V4 stated that R3 re the following Monda that the incident occ that R3 reported that did not feel comfort staff in the psych scome and talk with has built a good rap R3 is alert, oriented appropriately. V4 stated that R3's leg and sat on reported that R4 the touched her genitals that R3 said No and	coo AM V4, Social Services to R3 notified her of an incident. Exported the incident to her on ay. V4 stated that R3 reported curred on a Friday. V4 stated at it was at night and that she able with discussing it with the ocial. V4 stated that R3 does her from time to time and she opport with R3. V4 stated that and able to describe events ated that R3 informed her that the room and was awaken by R3 reported that R4 touched the bed. V4 stated that R3 en hugged R3 and then as. V4 stated that R3 reported that R4 then left the room. V4 and that the touch was				
	stated that she is fa R4 is a sexual man with sexual behavior aware of him doing consensual, but he inappropriate behavior On 9/30/2024 at 2:5 Director, stated that incident on the follo					
	R3 is alert and does up stories. V10 stat wanted a room to m	s not have a history of making ed that R3 voiced that she nove before this happened. is not aware of R4 having this				

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On 9/30/2024 at approximately 2:15 PM V1,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
	IL6007983	B. WING		I	C 02/2024
NAME OF PROVIDER OR SUPP	'	DDRESS, CITY, S	TATE ZIP CODE	,	
		ROME LANE	TATE, ZII GODE		
BRIA OF CAHOKIA		A, IL 62206			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S9999 Continued From	m page 8	S9999			
Administrator, substantiate th against hers. Ventered room ther genitals. Viwent in the rook R3 but denies on 10/1/2024 at that was provided on 10/2/2024 at that was provided on the following reported that situated that she told Restated that she the incident eashe was but where the incident eashe was but when the incident eashe was shall be incident eashe was R4 being findicate that the that she did se admitted to goi hugging R3 but stated that she	stated that she could not e allegation because it's his word it stated that R3 reported that R4 ouched her leg, knee and grouped it stated that R4 admitted that he im, touch R4's knee and hugged touching R3's genitals. at 1:20 PM V1 stated that the policy led is the Abuse Prevention policy. at 1:40 PM V5, License Social that R3 reported to V5 the incident gmorning. V5 stated that R3 ne was sleep in her room and R4 her leg above her knee. R4 gave then reached down to R3's pubic led that she was informed by R3 and and he left the room. V5 asked R3 why she didn't report riler and was notified by R3 that hen she goes to the psych social, be quiet and go away. V5 stated that she didn't think they would stated that R3 reported that she v4. V5 stated that R3 does have a mood trauma and abuse. V5 stated that this triggered R3 and of details of the childhood abuse. R3 voiced she it made her feel that R4 gave her a while ago riendly. V5 stated that R3 did le touch was unwanted. V5 stated that R4 gave her a while ago riendly. V5 stated that R3 did le touch was unwanted. V5 stated le R4 on that same day and R4 ng in room, touching R3's leg and to denies touching R3's genital. V5 has not witness R4 being sexually ut have been notified by stated				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II TIDI	E CONSTRUCTION	(X3) DATE	CLID\/EV
	OF CORRECTION	IDENTIFICATION NUMBER:	l ` ′			LETED
			A. BUILDING.			
			D WING			
		IL6007983	B. WING		10/0	2/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DD14 05	0.41101/14	3354 JER	OME LANE			
BRIA OF	CAHOKIA	CAHOKIA	, IL 62206			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	·	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				,		
S9999	Continued From pa	ge 9	S9999			
	the past.					
	the past.					
	The facility's Abuse	policy, dated 9/2017,				
		: This facility affirms the right				
	of our residents to b	pe free from abuse, neglect,				
		propriation of property or				
		facility therefore prohibits				
		loitation, misappropriation of				
		eatment of residents. In order				
	resident sensitive a	has attempted to establish a				
		urpose of this policy is to				
		lity is doing all that is within its				
		ccurrences of abuse, neglect,				
		propriation of property and				
		idents. Abuse: Abuse means				
		ntal injury or sexual assault				
		dent other than by accidental				
		5/1-103). Abuse is the willful				
		nreasonable confinement,				
		ishment with resulting physical				
		tal anguish to a resident (42 lso includes the deprivation by				
	,	ling a caretaker, of goods or				
		ecessary to attain and/or				
		nental, and psychosocial				
		sumes that all instances of				
	abuse of residents,	even those in a coma, cause				
		in or mental anguish (42 CFR				
		Guidelines). The term "willful"				
		abuse" means the individual				
		eliberately, not that the				
		e intended to inflict injury or				
		.5). Sexual Abuse includes, sexual harassment, sexual				
		assault by a licensee,				
		(77 III. Adm. Code 300.330).				
		n-consensual sexual contact				
		esident. (42 CFR 483.5 and				
	483.12 Interpretive					

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PRINTED: 11/19/2024

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С IL6007983 B. WING ___ 10/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE BRIA OF CAHOKIA

BRIA OF		CAHOKIA, IL 62206		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	JLL PREFIX ON) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
S9999	Continued From page 10	S9999		
	(B)			

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