STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S 000	Initial Comments Complaint Investigation: 2442466/IL171331	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 300.3240b) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	S9999		

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failed to prevent abuse for 1 of 3 (R7) residents reviewed for abuse in a sample of 12. The facility also failed to initiate its abuse policy and report allegations of abuse for 2 of 3 (R6, R7) residents. This failure resulted in R7 experiencing pain, being fearful, feeling trapped, unprotected, and feeling less than a man. This failure also resulted in R6 feeling unsafe and as if no one cares.

Findings include:

1. R7's Care Plan, dated 12/11/23, documented, "ABUSE: (R7) is at risk for abuse and neglect r/t (related to) his impaired mobility. He is noted to make false allegations toward staff. 8/15/2023 Resident reported that CNA (Certified Nursing Assistant) was rough while providing care. 11/27/2023 Resident reported that a CNA was rough while providing care." It continues, "Assure resident that he/she is in a safe and secure environment with caring professionals. Explain that psychosocial adjustment is often facilitated by developing a trusting relationship with another person (i.e., social worker, nurse, CNA, peer) and by verbalizing thoughts, needs and feelings. Immediately report any episodes of unknown injury, abuse or change in resident's behaviors to Administrator for immediate intervention and review. Observe the resident for signs of fear and insecurity during delivery of care. Take steps to calm the resident and help him/her feel safe. Assure the resident that staff members are available to help, and department heads maintain an "open door" policy."

R7's Minimum Data Set, dated 1/18/2024, documented that R7 is moderately cognitively impaired.

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R7's Police Report, dated 3/7/2024, documented, "On Thursday March 7, 2024, I (V20, Sergeant) was dispatched to (facility) in reference to Elderly Abuse. Upon arrival I exited my patrol car and walked into the lobby where I was met by an unknown black female. The female later known as (V2 Director of Nursing/DON) stated she was the staff director and she had complaints on two of her employees for elderly abuse. (V2) stated a male in room (number) later known as (R7) advised her that he was getting beat on and verbally abused by two staff members. (V2) then escorted me to room where (R7) resides at. 1 walked into room and noticed (R8) white male with what looked as if both of his legs were amputated. I then asked (R7) did he need to speak with the police. (R7) stated he did need to speak with the police because he was getting abused, and he had a witness. I then asked (R7) what happened. (R7) stated two of the nurse's aides one known as (V17) and the other one known as (V18) abused him physically and mentally. (R7) stated he needed to be changed and the female (V18) was mad that she had to do her job and started slamming him to the wall and hurting him more. (R7) stated he was yelling and telling (V18) that she was hurting him more. (R7) stated he then was asking (V18) why was she treating him like that. (R7) stated (V18) continued to ruff him up and he kept yelling for her (V18) to stop. (R7) stated that when (V17) told him to shut the f*** up because nobody has time for that bull s**t. (R7) stated he has a roommate who witness the whole thing. I then spoke with (R7's) roommate white male later known as (R8). I asked (R8) did he witness what happened to (R7). (R8) stated yes. (R8) stated he first heard some loud bumping sounds to the wall. (R8) stated he then heard (R7) stop you are hurting me. (R8) stated he then got up to see what was

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going on. (R8) stated he seen what the nurse was doing to (R7) by slamming him to the wall and refusing to do their job properly. (R8) stated he then told (V18) to stop what she is doing because she is hurting him. (R8) stated (V18) and (V17) then started cursing him out and telling him to shut the f*** up. (R8) stated they then left the room. (R7) stated later (V2) came in the room and he reported it to her and advised her that he wanted to make a police report. Then asked (V2) where was the two females that was in question. (V2) stated that they both are on administration leave. I provided (R7) with a report number and advised him that his report will be on file. I also advised (R7) that this matter will be turned over to our deceives division for further investigation."

R7's Customer Concern and Feedback Form, dated 3/5/2024, documented, "Resident reported that the CNAs were handling him rough while cleaning and drying him. Follow up: the CNAs never intended to hurt or harm the resident while turning him and providing care. His foot accidently hit the wall."

On 4/8/2024 at 1:09 PM, R7 stated that he remembers what happened. R7 stated that he had his call light on for hours. R7 stated that he had his roommate go and try to get help and the staff would not come. R7 stated that when they came in the room, they were loud and yelling at him. R7 stated that V17 (CNA) and V18 (CNA) entered the room and said, "What do you want." R7 stated that he informed them that he was wet and had a bowel movement. R7 stated that he told them that he had been laying in it for hours. R7 stated that they were trying to get in and out. R7 stated that he was thrown against the wall and his leg hit the wall several times. R7 stated that he informed them that it hurt but they continued

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and did not stop. R7 stated that they kept pushing him and each time he would hit the wall. R7 stated that he knows that he is a large guy, but this was excessive. R7 stated that he felt mistreated and abused. R7 stated that they would not listen. R7 stated that he kept saying it was hurting and nothing. R7 stated that he was being abused. R7 stated that this was the third time. R7 stated that the first two times he didn't say anything, but this was excessive. R7 stated that V2 (DON) asked him about not receiving care and he informed her of this. R7 stated that he identified V17 (CNA) and V18 (CNA) as the staff that did this. R7 stated that he was informed that those employees were currently suspended and would not be returning to the facility. R7 stated that he felt better and safe at that time. R7 stated that the V4 (Assistant Administrator) came and talk to him a couple of days later. R7 stated that he told her that he felt safe at that time because he was told that they no longer worked at the facility. R7 stated that a week or so later he was notified that they would be returning to work and stated that he was upset. R7 stated how is that? "How can someone hurt you and come back?" When asked if he thought the act was intentional or deliberate R7 stated that he told them that it hurt and to stop. R7 stated that they told him to shut up and kept pushing. "Now if that's not intentional or deliberate. I don't know what is." R7 stated that he spoke with V2 and verified that the staff would be returning. R7 stated at the time I feared for my safety. R7 stated that he called the police that day and reported it. R7 stated that he does not feel safe at the facility. R7 stated that they are still here and can hurt him at any point hurt him. R7 stated that he feels trapped and unprotected. R7 stated that its demeaning and as a man having to depend on them and they hurt you and you can't fight back or defend your self

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makes you feel less than a man. R7 stated that he feels like he is going to die in this facility.

On 4/8/2024 at 2:24 PM V10 (CNA) stated that R7 was alert and able to make needs known. V10 also stated that R7 can answer questions appropriately and truthful. V10 stated that R7 keeps a book with his concerns in it with dates, names, and times.

On 4/8/2024 at 12:53 PM, R8 stated that he has been roommates with R7 for a while. R8 stated that he was here when the incident occurred. R8 stated that R7 had his call light on for hours. R8 stated that he went to the nurse's station several times to get help and the staff would not come and said they were not coming. R8 stated that later that day V17 (CNA) and V18 (CNA) came in the room and asked, "What do you want?" R8 stated that shortly after that he could hear a bumping sound and then R7 saying ouch, stop, you're hurting me. R8 stated that he got up to find out what was going on. R8 stated that there were 2 girls. One girl was standing back, not helping, talking to the other girl. The second girl was pushing R7 against the wall. R8 stated that she was trying to clean R7. R8 stated that R7 was saying that it hurt but the girl kept pushing. R8 stated she was rough. R8 stated that when he told them that it was hurting R7 he was told to shut the h*** up.

R8's MDS, dated 1/31/2024 documents that R8 is cognitively intact.

On 4/8/2024 at 2:30 PM V2 (Director of Nursing) stated that on February 27, 2024, she spoke with R7 about care concerns. V2 stated that at that time R7 informed her that he does not get care. V2 stated that he has his light on for long periods

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of time without being answered. V2 stated that R7 informed her that when the aides come into the room, they are mad and rough with him. V2 stated that R7 informed her that V17 and V18 came to his room and cleaned him up and when they entered, they asked what did he want? V2 stated that R7 said he needed to be changed and V17 and V18 began cleaning him. V2 stated that R7 informed her that they threw him against the wall and hurt his legs. V2 stated that he told them to stop that it hurt, and they continued and did not stop. V2 stated that they kept pushing R7 against the wall and hurting him. V2 stated that she has not seen this behavior from V17 or V18. V2 stated that she has seen V18 yelling and refusing to perform care which she was suspended for. V17 stated that V17 and V18 were suspended for separate incident when she became aware of R7's concerns. V2 stated that when this issue was brought to her attention and after interviewing R8 and R7 she found them to be creditable and truthful. V2 stated that the V4 told (the administrator at the time) immediately. V2 stated that V17 and V18 had been suspended for an unrelated issue and with these abuse findings were terminated. V2 stated that the union got involved and the employees allowed to return. V2 stated that she had not spoken to or interviewed V17 and V18 until March 5 when they came in with the union representative. V2 stated that at that time V18 denied that this had occurred and V17 stated that she had not worked with R7 and had not been assigned to R7. V2 stated that V17 stated that R7 mixes her and V19 up and V19 is the staff member that works with R7. V2 stated that she did not interview V19 because R7 said that this happened on the weekend and during the week. V2 stated that she did not interview any other staff.

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On 4/9/2024 at 10:17 AM V4 (Assistant Administrator) stated that she was the administrator at the time of the allegation. V4 stated that she went down and talked with R7, and he said that he felt safe at that time and did not feel the need to go any further.

2. R6's Care Plan, dated 2/2/24, documented, "ABUSE: (R6) is at risk for abuse and neglect r/t (related to) CHF (congested heart failure), weakness, malnutrition, hemiplegia and depression." It continues, "Observe the resident for signs of fear and insecurity during delivery of care. Take steps to calm the resident and help him/her feel safe."

R6's Minimum Data Set (MDS), dated 1/31/2024, documented that R6 was cognitively intact and required assistance from staff to complete tasks.

R6's Grievance, dated 3/25/2024, documented, "(R6) stated on the Friday 22nd day of march, he had a BM on himself approximately 3xs. He called for CNA at 8pm and was not serviced until 8am. Follow up (R6) refused care and was verbally abusive to any staff that tried to clean him that night. (V2 DON) present that Saturday morning and was able to get 2 female staff to clean him up."

On 4/5/24 at 10:05 AM V2 (DON) stated that she had received a complaint from a state surveyor when she was at the facility doing another survey that a couple of male residents, R6 and R7, had reported to her that two female CNAs were rough with them and felt like they were abusive. V2 stated she had suspended the CNAs and did an investigation. She stated that the two CNAs were V18 and V17. V2 stated after the investigation

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she did feel like the allegations were substantiated and felt like the CNAs should have been terminated but the union got involved and stated that the CNAs had to be brought back, so they returned to work. V2 continued to state that she did report the allegation to the V4 (Administrator) and the surveyor also reported the allegations to the (V4), but she does not know if the Administrator reported it to the state or not. V2 stated that the investigation went on for almost 3 weeks and her investigation showed they were guilty. She stated she spoke to R7's roommate, R8, who stated staff were rough with (R7). She stated (R7) called the police himself to report the incidents. She stated when the CNAs were brought back, they were told to not have any contact with the two male residents involved.

On 4/5/2024 at 10:50 AM V4 (Assistant Administrator) stated that she was the administrator at the time of the incident. She stated that she did not report the allegation because (R6) has always complained about the staff and only lets a few of them take care of him. She stated that she did talk to both of the residents at different times but did not state it was specifically about the allegation.

On 4/8/2024 at 1:20 PM, R6 stated that he was not being cared for. R6 stated that his call light stays on for long periods of time and when the staff come in, they are rude and disrespectful. R6 stated that he has told them to leave the room when they are being rude. R6 stated that he prefers girls to men when it comes to his care. R6 stated that it takes them a long time to come to the room then they have an attitude when I am the one who should be mad not them. How does that work. R6 stated that it takes hours. Sometimes I lay in my own filth all night. R6

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stated that when they come in, they are rough and curse you out. R6 stated that they are abusive. R6 stated that he notified V2 (DON) about it and that the staff were being verbally abusive.

The facility's Abuse policy, dated 9/2017, documented, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents." It continues, "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. The term "willful" in the definition of "abuse means the individual must have acted deliberately, that the individual must have intended to inflict injury or harm." It continues, "Any allegation of abuse or any incident or accident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. As used herein, "serious" means any incident or accident that causes physical harm or injury to the resident. Any incident or accident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. VIII. External Reporting: 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has been made, the administrator, or designee, shall notify Department of Public Health's regional office

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immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property has been reported to the administrator and is being investigated. The report shall include the following information, if known at the time of the report: Name, age, diagnosis and mental status of the resident allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated; Type of abuse reported (physical, sexual, verbal or mental abuse, neglect, exploitation, misappropriation of resident property, unreasonable confinement or involuntary seclusion); Date, time, location and circumstances of the alleged incident; Any obvious injuries or complaints of injury; Steps the facility has taken to protect the resident. This report shall be made immediately. As used herein, the term "immediately" in relation to reporting abuse, neglect, exploitation, mistreatment, misappropriation of resident property, and suspicion of a crime shall be defined as, "following management of the immediate risk to the resident or residents, including the administration of necessary medical attention, and establishing the safety of the resident or residents involved" or not later than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause suspicion do not result in serious bodily injury. 2. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. (42 CFR 483.12}. The final investigation report shall contain the

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S9999	Continued From page 11 following: Name, age, diagnosis and mental status of the resident allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated; The original allegation (note day, time, location, the specific allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries} A summary of facts determined during the process of the investigation, review of medical record and interview of witnesses; Conclusion of the investigation based on known facts; The police report, if applicable; If the allegation is determined to be valid and the perpetrator is an employee, a separate sheet listing the employee's name, address, phone number, title, date of hire, copies of previous disciplinary actions, and current employment status (still working, suspended or terminated)." "C"	S9999		