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 02/21/2025

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

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: #2540629/IL185134 #2540911/IL185612	S 000		
S9999	Final Observations Statement of Licensure Violations: ONE OF TWO 300.610a) 300.1210b) 300.1210d)6) 300.3210t) 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	S9999		

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 02/21/2025

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S9999	Continued From page 1	S9999		

each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be 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.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements were not met as evidenced by:

Based on interview and record review the Facility failed prevent resident to resident verbal and physical abuse for 8 of 13 residents (R1, R23, R24, R28, R29, R33, R43, R44) reviewed for abuse in the sample 51. This failure resulted in R43 throwing a punch, falling from his chair, and fracturing his hip.

Findings include:

1. R43's Physician Order Sheet (POS) dated

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 02/21/2025

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

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S9999	Continued From page 2	S9999		

January 2025 documents diagnoses of Paranoid Schizophrenia, need for assistance with personal care, weakness, displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture (1/27/2025), unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance and anxiety, brief psychotic disorder.

R43's Minimum Data Set, MDS, dated 12/19/2024 documents R43 was cognitively intact for decision making of activities of daily living. R43's MDS documents R43 has no impairment on his upper and/or lower extremity and with most Activities of Daily Living (ADL's) "Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently."

R43's Care Plan: Abuse/Neglect: At risk for abuse and neglect r/t (related to) DX (diagnosis of) Paranoid Schizophrenia, Psychosis, behaviors such as delusions and hallucinations. Goal with a target date of 12/12/2024, "Staff will monitor well being of others. Resident will have zero episodes of abuse and neglect throughout the next review. R43's resident to resident altercation on 1/25/2025 was not noted on the R43's current care plan.

R43's Nurse's Notes dated 1/23/2025 at 5:33 PM, "Res (Resident) has been admitted to (Psych Hospital) r/t (related to) r (right)/femur fx (fracture)."

R43's Initial Report dated 1/23/2025 at 8:00 AM, "Resident to Resident altercation was reported. Resident (R44) was in the bathroom when resident (R43) barged in and was upset (R44)

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 02/21/2025

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

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S9999	Continued From page 3	S9999		

was taking too long. Residents made contact and resident (R44) came to report the incident to (V27) Psychosocial Director. Both residents were immediately separated and assessed. MD (Medical Doctor) and POA (Power of Attorney) notified, more to follow pending final investigation."

On 2/6/2025 at 2:34 PM, V27, Psychosocial Director stated, "(R44) came to me I was sitting here at my desk working on the computer and he said, '(V27), (R43) is on the bathroom floor. 'I said, 'what is he doing on the bathroom floor?' and he said, 'I was in the bathroom washing a cup and (R43) got upset because I was taking too long and called me the 'N' word and then hit me in the face, so I hit him back and he's on the bathroom floor now. I then reported it to the nurse. (R43) messes with everyone and usually everyone ignores him. I think he went too far this time and (R43) got hurt. I think he fractured his hip."

On 2/13/2025 at 10:46 AM, R43 stated, "I hurt my hip when I slipped and fell and broke my hip. I hit (R44) but I apologized. I was mad and hit him in the bathroom and then he hit me back and I fell."

R43's Final Report dated 1/23/2025 at 8:00 AM, "Resident to Resident altercation was reported. (R44) was in the bathroom when resident (R43) barged in and was upset (R44) was taking too long. Residents made contact and resident (R44) came to report the incident to (V27), Psychosocial Director. Both residents were immediately separated and assessed. MD (Medical Doctor) and POA (Power of Attorney) more to follow pending final investigation. On final investigation it was found that (R44) was getting water from the bathroom sink and (R43) barged in and

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

demanded (R44) to get out. Resident (R43) made contact with resident (R44). Resident (R44) made contact back and exited the bathroom. (R43) was moved off the Psychosocial hall and has had no further altercations since."

R43's Involuntary Discharge papers undated documents, "Patient punched another resident in his arm and started using racial slurs calling the other patient a 'N' word. Patient is rambling words and hard to redirect. Patient stated if he sees the other person again, he will hit him."

R43's Hospital Records dated 1/23/2025 document, "66-year-old male, independent ambulatory without assistive devices, residents in nursing home. He was involved in altercation today at the nursing home when he and another resident were arguing over a cup of water. He fell and landed on his hip with subsequent pain and inability to bear weight. He presented to emergency department where he was found to have intertrochanteric fracture. The patient is admitted for further observation status post orthopedic surgery. X-ray document intertrochanteric fracture of right femur (Broken Hip), intertrochanteric fracture of femur."

R44's January 2025 POS documents diagnoses of disorganized schizophrenia, cognitive communication deficit, paranoid schizophrenia, major depression, type 2 diabetes mellitus with hyperglycemia, and need for assistance with personal care.

R44's MDS dated 11/13/2024 documents R44 was cognitively intact for decision making of activities of daily living.

R44's Care Plan: under Abuse documents, "At

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

risk for abuse and neglect r/t (related to) his dx (diagnosis of) Schizophrenia. 5/22/2023 Resident was accused of inappropriate behavior with a peer. 9/23- inappropriate behavior towards another resident. The Care plan does not address the 1/23/2025 abuse.

R44's Nurse's Notes dated 1/23/2025 at 5:14 PM, documents "nurse was notified by staff that resident was in an altercation with another resident, another resident tried to force this resident out of the bathroom, this resident asked if he could wait which lead to altercation, resident stated he was asked by the resident to get out the bathroom, resident stated he told him to wait till he was done, he stated the resident started using racial slurs and calling names and then it was lead to an altercation between the two, resident also stated that resident then tried walking back to the room once altercation was over, but then lost balance and fell, np (Nurse Practitioner) and psych np was notified, called POA (Power of attorney) and left VM (voicemail), no answer at this time, no injuries noted upon skin assessment, resident remains in stable condition, remains at normal baseline with no complications."

R44's Initial Report dated 1/23/2025 at 8:00 AM, "Resident to Resident altercation was reported. Resident (R44) was in the bathroom when resident (R43) barged in and was upset (R44) was taking too long. Residents made contact and resident (R44) came to report the incident to (V27) Psychosocial Director. Both residents were immediately separated and assessed. MD (Medical Doctor) and POA (Power of Attorney) notified more to follow pending final investigation."

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 02/21/2025

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

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S9999	Continued From page 6	S9999		

R44's Final Report dated 1/23/2025 at 8:00 AM, documents "Resident to Resident altercation was reported. (R44) was in the bathroom when resident (R43) barged in and was upset (R44) was taking too long. Residents made contact and resident (R44) came to report the incident to (V27), Psychosocial Director. Both residents were immediately separated and assessed. MD (Medical Doctor) and POA (Power of Attorney) more to follow pending final investigation. On final investigation it was found that (R44) was getting water from the bathroom sink and (R43) barged in and demanded (R44) to get out. Resident (R43) made contact with resident (R44). Resident (R44) made contact back and exited the bathroom. (R43) was moved off the Psychosocial hall and has had no further altercations since."

On 2/6/2025 at 2:13 PM, R44 stated, "I remember when I got into it with (R43). I was in the bathroom and then (R43) came in and he pushed me against the wall and hit me in the lip. (R43) was mad because I guess he thought I was taking too long. He is a bully, and he was yelling and screaming at me. He was going to hit me again, but I hit him back and then he fell on the floor. I did not think I hit him that hard and he hit me first. Then I went and told (V27, Psychosocial Director) what had happened."

2. R28's POS dated January 2025, document diagnoses of alcohol abuse, chronic obstructive pulmonary disease, difficulty in walking, muscle weakness, major depression disorder and hypertension.

R28's MDS dated 11/19/2024 documents R28 is cognitively intact for decision making of activities of daily living.

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 7	S9999		

R28's Care Plan date initiated of 6/2/2021 under Abuse documents, "(R28) is risk for abuse and neglect r/t (related to) his history of ETOH (ethyl alcohol or ethanol abuse) and major depressive disorder. Mr. Ray is known to leave for LOA (Leave of Absence) and return to the facility under the influence of alcohol. He admits to drinking beer and liquor. He denies having a problem with alcohol and does not want to seek treatment at this time. He has been educated on the impact of his use on his medical diagnoses and need to withhold medications when he is under the influence."

R28's Progress Notes dated 10/11/2024 at 11:53 AM, documents "Note Text: After another resident's w/c (wheelchair) became locked with his, (R28) balled up his fist and struck said resident in the chest 2 times."

R28's Initial Report documents on 10/11/2024 at 10:45 AM, "It was reported that (R33) and (R28) were in the Psych/social office. (R33) was trying to back up, and his wheelchair bumped into (R28's) wheelchair, and their wheels locked together. It was reported that (R28) hit (R33) in the chest twice with a closed fist. (R33) hit (R28) back (staff reported he was slapping at him). Both residents were separated for their safety. Officer (V20), Local Police reported to the facility. Residents' physician and responsible parties notified. (R28) was sent to (Psych Hospital) for evaluation. (R33) was assessed with no apparent injuries noted. Final investigation to follow."

R28's Final Report documents on 10/11/2024 at 10:45 AM, "It was reported that (R33) and (R28) were in the Psych/social office. (R33) was trying to back up, and his wheelchair bumped into (R28's) wheelchair, and their wheels locked

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

together. It was reported that (R28) hit (R33) in the chest twice with a closed fist. (R33) hit (R28) back (staff reported he was slapping at him). Both residents were separated for their safety. Officer V20, Local Police reported to the facility. Resident's physician and responsible parties notified. (R28) was sent to (Psych Hospital) for evaluation. (R33) was assessed with no apparent injuries noted." (same as initial report).

The Undated Statement from, Psychosocial Director, V27, documents, "On Friday, 10/11/2024 at approximately 10:45 AM, Resident (R33) was observed bumping into resident (R28's) chair. This worker then observed staff redirect (R28) to stop. This worker observed (R28) hitting (R33), the two were separated and redirected."

Statement from V28, Activity Aide dated 10/11/2024, documents "(R28) was in Psyche Social and the resident (R33) was trying to back his chair and he bumped his chair into and (R28) hit (R33) in his chest two times (R33) hit him back but not that hard."

R33's POS for January 2025 documents diagnoses of unspecified mood (affective) disorder, need for assistance with personal care, weakness, alcohol abuse, unspecified dementia, unspecified severity without behavioral disturbances, and depression.

R33's MDS dated 10/1/2024 documents R33 has memory problems and is severely impaired for cognition of activities of daily living.

R33's Care Plan with a date initiated of 7/20/2023 documents, "ADL (Activities of Daily Living) with daily care need related to cognition decline,

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 9	S9999		

including incontinence of bowel and bladder."

R33's Progress Notes dated 10/11/2024 at 12:50 PM, Note Text documents "Pt (Patient) was struck in the chest with a closed fist by another resident. Pt presents No difficulty breathing, currently eating in dining area. Appetite good. Pleasant affect and easily approachable yet confused. Pt denies any pain. No obvious deformity of the chest. Lungs CTA (Clear to auscultation). Chest Excursion normal for Pt. no obvious bruising or discoloration, will continue to monitor for change. Skin intact over chest wall."

R33's Progress Notes dated 10/11/2024 at 1:08 PM, documents "Note Text: After resident's wheelchair became locked with his. (R28) balled up his fist and struck said resident in the chest two times. (Local Police) responded and took report."

On 1/30/2025 at 2:49 PM, V29, Family of R33, stated "the bottom line was that my brother was declining and becoming more forgetful. When he was involved in the incident we do not think (R33) intentional tried to hurt anyone and because of his confusion he was in the wrong place at the wrong time, accidentally bumped into someone and then was hit with a fist hand in his chest two times. (R33) did not know what was happening. It's quite sad. We moved him to a different facility hoping that if it happened again, the resident would be more understanding."

3. R1's POS dated January 2025 documents diagnoses of Paranoid Schizophrenia, anxiety disorder, cannabis abuse, depression, cognitive communication deficit.

R1's MDS dated 1/27/2025 documents R1 was

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

cognitively intact for decision making of activities of daily living.

R1's Care Plan with target date of 1/26/2024 does not address abuse.

On 1/28/2025 at 4:24 PM, R1 stated, "(R29) told me he wanted to f*** me in my butt until I bled. I told the staff because I don't know him and who would say something like that. They called the police and send him out, but he came right back, and he tried to approach me again, but I went and got the nurse. I don't even know him. I try and stay away from him. He is saying stuff like that to staff too. I heard him say the same thing to (V16, Licensed Practical Nurse, LPN). When he is around, I don't feel safe. I feel like he wants to fight me or hurt me. I try and keep my distance and when he approaches me, I try and get a nurse. I think he wants to hurt me. I think something is wrong with him and I just don't want him around me. He scares me. He said the same thing to a nurse, (V16). Something is not right with him."

R1's Incident Report date of incident 1/21/2025, documents "Verbal resident altercation was reported in the dining room. Resident (R29) spoke inappropriate comments to (R1). The incident was reported to the nurse. Nurse (V16) stayed with resident (R29) until EMS (Emergency Medical Services) and Police showed up. Resident (R29) is being sent out for a psych evaluation. MD and POA notified. More to follow pending final investigation. Upon final investigation it was noted that resident was having increased behaviors and speaking inappropriate to residents and staff even upon return. Residents was sent back from hospital and Resident was seen but Psych NP (Nurse

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 11	S9999		

Practitioner) and medications were changed for resident's increased behaviors. Resident was sent back out to the hospital for involuntary psych evaluation. Upon resident return he will be put on behavior monitoring for inappropriate comments, will be involved in group therapy sessions, and activities as needed."

R29's POS January 2025 documents diagnoses of Schizoaffective, anxiety, depressive, and a history of substance abuse.

R29's Care Plan date initiated of 10/26/2023 documents, "(R29) has symptoms such as mood swings, impulsive behaviors, and attention seeking behavior related to a diagnosis of Bipolar Disorder/schizoaffective disorder, depression and ADD (Attention Deficit Disorder). He takes medication as orders."

R29's Care Plan with a date initiated of 1/9/2025 under Abuse, the Goal documents, "staff will monitor wellbeing of others. Resident will have zero episodes of abuse and neglect." The Care Plan does not document R29 making sexually inappropriate comments.

R29's MDS dated 1/6/2025 documents he is cognitively intact for decision making for activities of daily living.

R29's Social Service Note dated 10/4/2025 at 11:14 AM, documents "Note Text(*R29) is A&O x 3 (alert and orientated x 3). His BIMS (Brief Interview for Mental Status) is a 15 (cognitively intact for decision making). He has a diagnosis of Schizoaffective, anxiety, depressive, and a history of substance abuse. He is a current smoker and loves to chase the women. He was encouraged to be mindful of respecting others space, to

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 02/21/2025

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

(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) COMPLETE DATE
S9999	Continued From page 12	S9999		

proceed with caution."

R29's Incident Report date of incident 1/21/2025, documents "Verbal resident altercation was reported in the dining room. Resident (R29) spoke inappropriate comments to (R1). The incident was reported to the nurse. Nurse (V16) stayed with resident (R29) until EMS (Emergency Medical Services) and Police showed up. Resident (R29) is being sent out for a psych evaluation. MD and POA (Power of Attorney) notified. More to follow pending final investigation. Upon final investigation it was noted that resident was having increased behaviors and speaking inappropriately to residents and staff even upon return. Resident was sent back from hospital and Resident was seen but Psych NP and medications were changed for resident's increased behaviors. Resident was sent back out to the hospital for involuntary psych evaluation. Upon resident return he will be put on behavior monitoring for inappropriate comments, will be involved in group therapy sessions, and activities as needed."

On 2/14/2024 at 11:33 PM, V16, Licensed Practical Nurse (LPN) stated R29 had made a comment to her as well as stating he wanting to f*** her in the butt until she bleeds, and they sent him out.

4. R23's POS for January 2025 documents diagnoses of other generalized epilepsy and epileptic syndrome. Nicotine dependence, alcohol abuse, and paranoid schizophrenia.

R23's MDS dated 10/17/2024 document R23 was moderately impaired for cognition for activities of daily living. R23's MDS documents R23 walks and is independent for most activities of daily

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 02/21/2025

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

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S9999	Continued From page 13	S9999		

living.

R23's Care Plan date initiated of 10/1/2014. R23's Care Plan under ABUSE document: "At risk for abuse and neglect r/t Seizure disorder, Major depression, Schizophrenia, CVA, Lupus, Alcohol abuse, Seizure disorder. He is noted to be verbally aggressive and difficult to redirect at times. He is noted to have history of peer-to-peer altercations."

R23's Initial Incident Report dated 12/20/2024 documents, "Resident to Resident altercation. Resident (R23) and Resident (R24) made contact in the smoke line to go outside. Resident (R24) pushed staff member and then went to swing on the staff member and resident (R23) intervened. Residents were immediately separated. Both residents were sent out for evaluation due to behavior, MD (Medical Doctor) and POA (Power of Attorney) notified. More to follow in final investigation."

Final Report, dated 12/20/2024, documents "Resident to Resident altercation. Resident (R23) and Resident (R24) made contact in the smoke line to go outside. Resident (R24) pushed staff member and then went to swing on the staff member and resident (R23) intervened. Residents were immediately separated. Both residents were sent out for evaluation due to behavior, MD and POA notified. Both residents came back from the hospital and were free of any injury. Resident care plan was updated to reflect these found behaviors. Residents have had no further altercations."

On 1/31/2025 at 1:04 PM, V32 Dietary Aide stated, "Yes, I remember that day (R23) hit (R24). I was helping during smoke break and all of the

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 02/21/2025

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BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S9999	Continued From page 14	S9999		

residents were crowded together ready to go outside and smoke. There was an ambulance trying to get through and (R24) shoved one of the residents and I told him you can't shove people and because you shoved someone you cannot smoke now, and he got mad. I reached down the cart and he swung at me and hit me pretty hard. And as I was coming up, he tried to swing at me again and (R23) grabbed him and protected me. I think I would have got hurt really bad if (R23) had not been there. (R23) did not start it, he was just protecting me."

On 1/31/2025 at 1:32 PM, R23 stated he did hit (R24) but he was only protecting (V32) because (R24) was going to hurt (V32)."

R24's POS for January 2025 documents diagnoses of Schizophrenia, chronic obstructive pulmonary disease, unspecified speech disturbances, other specified hypoparathyroidism, cognitive communication deficit, muscle weakness, difficulty in walking, paranoid schizophrenia, and anxiety disorder.

R24's MDS dated 11/14/2024, documents R24 was cognitively intact for decision making of activities of daily living.

R24's Progress Notes dated 12/20/2024 at 5:37 PM, documents "Residents were lining up to go out for smoke break (R24) became agitated he pushed an aid and another resident. The resident he pushed then began to hit him and a physical fight ensued. workers managed to break them up and separated them into rooms. (R24) had a nosebleed but upon assessment vital signs were table and WNL (within normal limits), redness to nose and upper back area found upon assessment but otherwise no injuries and no

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 02/21/2025

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

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S9999	Continued From page 15	S9999		

complaints."

The Abuse Policy dated 10/2022 documents, "The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation, of property, deprivation of goods and services by staff or mistreatment. The facility therefore prohibits abuse, neglect, exploitation, misappropriate of property, and mistreatment of residents. In order, to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order, to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means."

(A)

TWO OF TWO
300.610a)
300.1210a)
300.1210b)
300.1210d)2)
300.1220b)3)

Section 300.610 Resident Care Policies

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 02/21/2025

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S9999	Continued From page 16	S9999		

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 17	S9999		

plan. Adequate and properly supervised nursing care and personal care shall be 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:

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide follow-up

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 02/21/2025

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BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S9999	Continued From page 18	S9999		

urology care per standards of practice for 1 of 3 residents (R28) reviewed for quality of life in the sample of 51. This failure resulted in a delay of R28's scrotal surgery, ongoing unnecessary pain which affects R28's quality of life.

Findings include:

R28's Physician's Order Sheets for February 2025 document diagnoses of alcohol abuse, uncomplicated, chronic obstructive pulmonary disease, Chronic obstructive pulmonary disease, Type 2 diabetes without complications, Need for assistance with personal care, Hyperlipidemia, Benign prostatic hyperplasia with lower urinary tract symptoms, Hypertension, pain in unspecified knee, unsteadiness on feet, difficulty in walking muscle weakness, inflammatory disorder of scrotum.

R28's Minimum Data Set (MDS) dated 11/19/25 documents R28 is cognitively intact for decision making of activities of daily living.

R28's Care Plan under skin document, "(R28) is at risk for skin complications related to surgical removal of lipoma to right upper back, resolved 2/15/2022". The Care Plan does not address any issues with his scrotum.

On 2/14/2024 at 1:03 PM R28's scrotum hung down lower than the other side and appeared abnormal with swelling present in that area.

On 2/14/2024 at 1:18 PM, R28 stated he had surgery on his scrotum a few years ago and they messed it up during surgery. R28 stated his testicles were together but now they are separate, and one is up, and one hangs down. R28 stated he has to be careful when he sits down because

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	IL6007983	A. BUILDING: _____ B. WING _____	C 02/21/2025

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BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S9999	Continued From page 19	S9999		

he can sit on the one that hangs down and it causes him pain and the area becomes tender. R28 stated the facility does give him pain medication for it. R28 stated he needs to get surgery to fix his scrotum really bad but has not been able to get an appointment and this has been going on for a few years now.

R28's Progress Note dated 12/21/23 at 10:35 AM, documents "Referral TO UROLOGY DX (diagnosis) encysted hydrocele (type of scrotal swelling that occurs when fluid collects in the thin sheath that surrounds the testicle) with history of repair last July 2023, recurrent hydrocele, Chronic, needs evaluation and treatment with urologist surgeon arrange with referral coordinator." (This surgery needed to be repeated).

R28's Progress Note dated 1/10/24 at 7:38 AM, documents "Arrange for clearance. Discussed with resident regarding this matter. orders were entered: The following: future surgery hydrocele repair; (R28) Surgery appointment scheduled on 2/14/2024 @ (at)1155a @ (Hospital) Instructions in PCC (Point click care) must arrive 2 hours prior to surgery. Nurse to contact Nurse practitioner Cardio for clearance for second time repair for his hydrocele surgery on Feb 14, 2024."

R28's Progress Notes dated 1/24/24 at 10:43 AM, documents "NP (Nurse Practitioner) cleared him to his surgery."

R28's Progress Notes dated 1/25/24 at 12:06 PM, documents "Spoke with Urologist due to high AIC 9.2 %, deferred his surgery at this time re-evaluate in 2 months."

R28's Progress Notes dated 1/24/2024 at 6:29

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 02/21/2025

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BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S9999	Continued From page 20	S9999		

AM, documents "Note Text: Surgery was canceled."

R28's 2025 medical record was reviewed and did not have any documentation regarding an upcoming appointment scheduled for his surgical procedure.

On 2/14/2025 at 2:03 PM, V46, Social Service Director stated, "I am new to this job. I have not completed my training and I am just learning. I am not sure why (R28) has not had an appointment for his surgery. I know at one time we were having issues with his insurance, and it was scheduled but then it was canceled. I am not sure why he has not had an appointment. I will look into it. We have a census of 118 residents."

On 2/14/2025 at 2:03 PM, V23, Licensed Practical Nurse stated, "(R28) has some issues with his scrotum and occasionally he will complain about it hurting in that area."

On 2/14/2025 at 3:13 PM, V2, Director of Nursing stated, "If a resident needed a follow up appointment, I would expect it to be scheduled and if there was a certain issue that it could not be scheduled I would expect staff to follow up and make sure it gets scheduled if it was indicated."

On 2/14/2025 at 4:45 PM, V46, Social Service Director, stated she was not sure what happened, but she just scheduled him an appointment for an evaluation to see what he needs or should be done.

On 2/21/2025 at 12:22 PM, V40, Medical Doctor of Urology stated, "I did a procedure on (R28) back in July of 2023. Originally, (R28) was supposed to have it repeated because of some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 21	S9999		

complications but there some issues with his blood work so it had to be delayed. We thought he would be rescheduled. I was the one who did the surgery, and we were working with the insurance company because I was the one who did the surgery. (R28) he was not in my network but then because of the delay, he must have slipped through the cracks because now too much time has elapsed, and the insurance provider will not let me bill because he is not in my network and too much time has passed. I would have thought he would have already had this procedure. We had it all fixed back in 2023 to repeat the procedure but now (R28) will need to find a new provider that is in hisnetwork. It is a shame because that is a lot of time has passed. The delay of course will affect his quality of life, some pain, maybe some inflammation. It is hard for me to say exactly because I have not put eyes on him since 2023. It can cause discomfort, pain, swelling. Nothing life threatening but it does affect his quality of life and is fixable."

The Appointment and Transportation Policy dated 9/2024 documents, "When a resident has an appointment outside of the facility, the staff will make the transportation arrangements, unless the responsible party chooses to make the arrangements themselves. Staff nurse or designee will call the place of the appointment to verify the date, time, and location. The staff nurse will notify the attending physician and any appropriate ancillary physicians (i.e. nephrologists) of the resident's appointment. If the resident will be missing any type of procedure or timed medication, the appropriate physician will be notified, and order received. (i.e. missed dialysis, missed IV meds, etc.) Staff nurse or designee will then call the family to see if they will be providing transportation and accompanying

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S9999	Continued From page 22	S9999		

the resident. If the family is not making transportation arrangements, the staff nurse or designee will call the transportation company (Medicare, ambulance, etc.) to set up the date and time of pick up. The pickup time should be at least one hour prior to the appointment. If the family will not be accompanying the resident, the staff nurse or designee will inform the DON (Director of Nursing) to determine if an escort is needed for the resident. Prior to the appointment, the staff nurse or designee will gather the necessary paperwork to send with the resident to the appointment. This includes a face sheet and continuity of care document, and other requested documents. On the day of the appointment, the staff nurse will ensure that the received personal care resident and dressed appropriately for the weather. All paperwork should be given to the family or driver for the appointment. If the resident is unable to keep the appointment, it is the staff nurse responsibility to cancel the appointment and reschedule it at the earliest time. If the primary physician had arranged the appointment, the staff nurse should alert them to the schedule change. The responsible party will also be notified of any appointment that is canceled and changed."

(B)