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: IL6007983 03/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIA OF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 000 Initial Comments S 000 Annual Licensure and Certification Survey S9999 S9999 Final Observations Statement of Licensure Violations: 300.690a) 300.1010 i) 300.1210 b)4) 300.1210 d)3) 300.1210 d)6) 300.1810 c)3) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures. 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

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

resident to meet the total nursing and personal

encourage residents so that a resident's abilities

4) All nursing personnel shall assist and

care needs of the resident.

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

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record, and written interpretive reports of diagnostic tests or specific treatments including. but not limited to, radiologic or laboratory reports

Based on observation, interview and record

and other similar reports.

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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: _ B. WING IL6007983 03/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIA OF CAHOKIA** CAHOKIA, IL 62206 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 review, the facility failed to provide safe, adequate Gastrostomy (G-tube) care for 1 of 1 residents (R13) reviewed for G-tubes in the sample of 47. This failure resulted in R13's G-tube being pulled out during care, requiring him to need hospitalization for surgical placement of a new G-tube. Findings include: On 3/24/21 at 12: 55 PM, R13 was observed receiving medication and a water flush through his G-tube. R13's Electronic Medical Record documents his diagnoses including Functional Quadriplegia, Aphasia, Gastrostomy Status, and Nontraumatic Subarachnoid Hemorrhage from Anterior Communicating Artery. R13's Minimum Data Set (MDS), dated 3/15/21, documents his cognitive status is severely impaired, and he is totally dependent on staff for bed mobility, transfers and eating, and that he has functional limitations in range of motion on both sides to his upper and lower extremities. R13's Physician Orders document the following orders: 12/10/20 NPO (nothing by mouth) diet; 3/19/21 Enteral Feed Order every shift related to Gastrostomy Status: Jevity 1.5 at 60 ml/hr (milliliters per hour) for 23 hours; 12/15/20 Check placement of G-tube using auscultation before administering food/meds/fluids; 12/15/20 Flush G-tube with 30 cc (cubic centimeters) of water before and after each medication administration. flush with 5 cc of water between medications: 12/15/20 G-tube residual - check and record every shift; 3/3/21 H2O (Water) flush 360 ml

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every 4 hours related to Gastrostomy Status:

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING ___ IL6007983 03/26/2021

NAME OF PROVIDER OR SUPPLIER

| NAME OF F | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, | STATE, ZIP CODE | | | | |
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| BRIA OF CAHOKIA | | 3354 JEROME LANE CAHOKIA, IL 62206 | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM | FULL | 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 3 12/15/20 Cleanse stoma site daily with a water during routine care. R13's Care Plan, dated 5/28/19, docum Resident is at risk for complications reladiagnoses: Conversion Disorder w/ Seiz Convulsions, Hydrocephalus, Gastro-es Reflux Disease, Depression, Vitamin D Deficiency, Aphagia, Urethral Stricture, Hypertension, Congestive Heart Failure Gastrostomy Gastrophoresis, Non-traur Subarachnoid Hemorrhage from Anterio Common Artery; receives tube feeding frutrition. R13's Progress Note, dated 2/18/21 at 6 documents, "Resident was transferred thospital) via ambulance at 6:20 PM. G-tbroken off and needs new one." This was and 10 minutes after the MD was notified G-tube had been pulled out. R13's Progress Note dated 2/19/21 at 6 documents, "Called (local hospital) for us Still waiting in ER (Emergency Room) for admittance. Needs surgery consult to G-tube as they were unable to replace e one." On 3/25/21 at 3:00 PM V1, Administrato presented R13's Untitled report of incideregarding R13's G-tube being pulled out 2/18/21 at 6:00 PM, which documents the physician was notified of R13's G-tube being pulled out at 4:10 PM. It does not include investigation of the cause of the incident new intervention to prevent it from happingain. There is no documentation of real | ents: ated to cures or cophageal matic or for all 5:17 PM, o (local cube had as 2 hours ad the :26 AM ipdate. or room o place existing or, ent d, dated ne peing e any t or any ening | \$9999 | | | | | |
| | was not sent to the hospital until 2 hours minutes after the MD was notified. ment of Public Health | s and 10 | | | | | | |

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On 3/25/21 at 2:10 PM, V22, Licensed Practical Nurse (LPN), stated R13 cannot voluntarily move his arms or hands and he would not be able to grab his G-tube and pull it out. She stated she did

not know how his G-tube got pulled out.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | | | |
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| AND PAN OF CORRECTION | | IDENTIFICATION NUMBER: | A. BUILDING: | | | COMPLETED | | | | | |
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| IL6007983 | | B. WING | B. WING | | 03/26/2021 | | | | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | | | | | | |
| BRIA OF CAHOKIA 3354 JEROME LANE | | | | | | | | | | | |
| 21111101 | | 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | (X5) COMPLETE DATE | | | | | |
| S9999 | Continued From page 5 | | S9999 | | | | | | | | |
| | On 3/25/21 at 2:44 stated there would r | PM V3, Regional Nurse, not have been an investigation ng pulled out because he was | | | | | | | | | |
| | Nursing (ADON), st placement of the G- | PM, V24, Assistant Director of ated staff should check the tube before turning and make sure they are not | | | | 1-7-0-7-0-7-0-7-0-7-0-7-0-7-0-7-0-7-0-7- | | | | | |
| | (RN) stated on the of the CNAs (Certified her and reported R1 stated the CNAs stated up and he's very stiff side, and his G-tube arm or hand and was he got down to his tube feeding formula blood. She stated sh to make sure the G-they are turning R13 watch them when the pulled out again. Sh that caused the tube | - | | | | | | | | | |
| | 1/2021, documents, potentially compens previous litigation ar reported to the insur coverage. All events the direction of the Canticipation of litigati be part of the defense defense counsel. Pro Other unusual occur | "Risk Management" reviewed "Purpose: An event is a able event, as determined by halysis. All events must be ance carrier to ensure must also be investigated at deneral Counsel in fon. Event investigations will se file and submitted to the focess: An event is: Level 3: frences requiring additional finues, "5. All events must | | | | | | | | | |

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