Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (AT) PROVIDENSUPPLIENCEIA (DENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		IL6007983	B. WING		C 07/14/	2023
			00500 0174 0	TITE 7/0 000F	1 01/14/	2023
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE A, IL 62206			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	22, 2023; June 17, June 27, 2023/IL16 Investigation of Fac	cility Reported Incident of May 2023; June 22, 2023; and				
\$9999	Final Observations		S9999			
	Statement of Licent 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.3210t) 300.3240e)	sure Violations:				
	a) The facility shall procedures govern facility. The written be formulated by a Committee consisti administrator, the a medical advisory confinersing and othe policies shall composite the facility and shall by this committee, and dated minutes	divisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating to be reviewed at least annually documented by written, signed of the meeting. General Requirements for				
	rtment of Public Health					

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

Electronically Signed

TITLE

(X6) DATE 07/26/23 Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6007983	B. WING	3 1528 TO 822 AS	07/1	; 4/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	-	
BRIA OF	САНОКІА	3354 JERO 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	a) Comprehensive facility, with the parthe resident's guard applicable, must de comprehensive car includes measurab meet the resident's and psychosocial nresident's comprehallow the resident to practicable level of provide for discharg restrictive setting be needs. The assess the active participal resident's guardian applicable. (Section b) The facility sha and services to attapracticable physical well-being of the releach resident's complan. Adequate and care and personal resident to meet the care needs of the releach shall be practiced and sha	Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act) Il provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with a properly supervised nursing care shall be provided to each te total nursing and personal esident. Desection (a), general nursing at a minimum, the following ted on a 24-hour, basis: Deservations of changes in a land, including mental and a quired and the need for alluation and treatment shall be aff and recorded in the	S9999			

Illinois Department of Public Health STATE FORM

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: C IL6007983 B. WING 07/14/2023 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)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 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. Section 300.3240 Abuse and Neglect e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent resident-to-resident physical and sexual abuse for 8 of 12 residents (R2, R8, R9, R12, R13, R14, R15 and R16) reviewed for abuse in the sample of 30. R15 struck R12 in the head with an unknown object causing a lump to R12's head. On a later date, R15 stabbed R16 in the left chest with a paring knife causing R16 to require emergency medical services and R15 was arrested and remains police custody; and R13 hit R14 on the head with an object and on a later date, R13 stabbed R14 in the head with a pen causing R14 to require emergency medical services and R13 was sent out for psychiatric evaluation.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		IL6007983	B. WING	B. WING		07/14/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BRIA OF	BRIA OF CAHOKIA 3354 JEF						
		_	, IL 62206	 			
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S9999	Continued From pa	ige 3	S9999		_		
	Findings include:						
	include Asthma, Dif Pain, Chronic Obst (COPD), Non-Displ Left Patella, Alcoho Gastroesophageal R15's Minimum Da documents he is ale independent with hi (ADLs).	t documents his diagnoses to fficulty in Walking, Low Back ructive Pulmonary Disease faced Longitudinal Fracture of al Abuse, Anemia and Reflux Disease (GERD). Ita Set (MDS) dated 3/31/23 ert and oriented and is Activities of Daily Living					
	had a resident-to-re 5/5/23 at 1:15 PM. dated 5/5/23, docur involved in an alterdand assessed. Full During the course of following facts were ambulating in the dahis forehead. When happened, he state (R15), had hit him in hard. (R12) was as no other injuries or that (R12) had been threatening to take of his room. (R15) resident but would rused during the alter performed on both concern were remogroup for anger machecks. The two mincidents or altercat	ent Report documented R15 esident altercation with R12 on The Facility's Incident Report, mented "Two male residents cation. Immediately separated I investigation to follow. of the investigation, the edetermined: (R12) was noted ay area with a lump noted to in (R12) was asked about what id another male resident, in the head with something seessed and was noted with impairments. (R15) stated in coming into his room and his phone and other items out admitted he struck another not admit to the item that was ercation. Room searches were men's' rooms and all items of eved. (R15) was placed in a nagement and for 15-minute iten have had no further tions since the date of this have maintained their prior					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	САНОКІА	3354 JERO CAHOKIA	OME LANE , IL 62206			
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S9999	documentation of w removed from R12's R15's Care Plan, da "Abuse: Resident is related to Chronic C Disease, Unspecific Resident is an Iden history of peer-to-peresident to resident peer altercation that was not documente were no updated intresident to resident until 5/30/23. These resident for abuse a and quarterly. Assusafe and secure emprofessionals. Expladjustment is often trusting relationship example, social worverbalizing thoughts the resident that stabelp, and departmedoor" policy. Contin ADLs, status, and becounseling schedulthe resident to verbanxieties, fears, cor Identify areas that pummediately report injury, abuse, or charto Administrator for review."	what items of concern were is and R15's rooms. Ate initiated 5/30/22, document at risk for abuse and neglect obstructive Pulmonary ed, and Alcohol Abuse. Itified Offender. He has a seer altercations. 6/25/23: Altercation." R15's peer to to cocurred on 5/5/23 with R12 ed on R15's Care Plan. There terventions after R15's Altercation with R12 on 5/5/23 e interventions include Assess and neglect upon admission are resident that he/she is in a vironment with caring lain that psychosocial facilitated by developing a with another person (for ricer, nurse, CNA, peer) and by so, needs and feelings. Assure aff members are available to ent heads maintain an "open nue to monitor medication, behaviors. Establish a e with resident. Encourage alize/share thoughts, incerns, and general feelings. Out resident at risk. Any episodes of unknown anges in resident's behaviors immediate intervention and	\$9999			

Illinois Department of Public Health STATE FORM

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: _ B. WING IL6007983 07/14/2023 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)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **TAG** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 5 S9999 and does not appear to present an unusual risk at this time. The Illinois Department of Public Health performed a Criminal History Analysis and made a determination regarding his level of risk. He was deemed a moderate risk. According to the resident's history he has been charged with unlawful possession of a weapon by a felon, Theft/Control/Firearm, Car Theft, and Aggravated Assault. The resident has a diagnosis of Alcohol. Abuse, Uncomplicated. Interventions for this care plan include Evaluate the resident's ability to control impulses, document accordingly. Teach impulse control strategies. Follow facility protocol addressing substance abuse. If substance abuse is suspected utilize appropriate blood/urine testing, limit setting, counseling, and consequences. Review the IDPH Criminal History Analysis (CHA). Implement suggestions. if reasonable and appropriate. Moderate risk interventions include appropriate supervision and observation, regular monitoring, attention to behavior changes, visual monitoring if warranted and periodic reassessment." The facility's document, "Facility-Reported Incident Form Initial Report" dated 6/25/23 documents, "On 6/25/23 at 8:25 PM Staff reported that they responded to loud voices, upon responding they observed (R15) and (R16) in verbal exchange. (R15) then was observed with small paring knife in his hand making contact with (R16's) left side rib area. The incident occurred in the doorway of Room (room number listed).

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of injury: puncture wound."

(R16) sustained a small puncture wound to lower left rib area. Physician notified; new orders received to send to ER (Emergency Room). Type

The facility's Follow-up Investigation Report. dated 6/30/23, documents, under Conclusion. Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		IL6007983	B. WING			4/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BRIA OF	CAHOKIA		OME LANE , IL 62206			
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S9999	"Staff reported that LOA (Leave of Abstrequesting snacks made a statement placing hands on (I staff saw something swinging arm toward Residents were impressed with (R15 (Emergency Medic escorted from facility provided pressure applied upprovided pressure attention with maladaptive brusing loud tone who (R16) has maintain signs of mental and psychosocial distrevisualized through asked, he states, "	(R15) had just returned from ence) with family, he was from staff at which time (R16) towards him resulting in (R16) R15) and giving a light push, g in (R15's) hand while rds (R16) making contact. mediately separated, staff b) until police, EMS at Services) arrived with (R15) ty by police. Licensed nurse to left lower rib area with entil EMS arrived. (R16) Emergency Room) for significant injury and/or all diagnostic testing negative. and review reveals he has a buse, history of ained family relationships and er Extremity) ROM (Range of the towakness. (R16's) lew: he has poor social skills, is which at times leads to thistory of Alcohol Abuse, tion seeking behaviors along ehaviors. He has a history of en expressing frustration. Led his usual routine with no guish noted and no less noted. He continues to be out facility interacting with citivities of his choice. When I'm fine." Police investigation stigation completed,	\$9999			
	document, "Descripto left chest. Review	cords dated 6/25/23 at 9:00 PM otion of Mechanism: Stabbing ew of systems: Respiratory: , sputum, dyspnea on exertion,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6007983	B. WING		C 07/14/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
RDIA OF	CAHOKIA	3354 JER	OME LANE			
DKIA OI	CAHORIA	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	pain from stab; Gas left upper quadrant. Sequelae of penetr wall without extensi peritoneal cavity. In chest. Plan: wound Follow up with traun R16's Face Sheet of include Major Depre Abscess of Right H Hypertension and A R16's MDS dated 5 and oriented and in R16's Care Plan do risk of abuse and n assault leading to ri					
	history of peer-to-peto peer incident; 6/2 altercation. On 6/29/23 at 3:15 in his room with a company bandage on his left and (R15) usually godominos out in the other residents. R1 would have words conothing serious. R15 was passing medic name so he went to R15 kept walking pabout R16 arguing being disrespectful between the nurse	PM R16 was lying on his bed slean, dry, intact white gauze side of torso. He stated he got along good and would play dining room with a couple of 16 stated sometimes they during a game but all in fun, 16 stated the agency nurse ations and had called his the door to get his meds and ast his door, saying things with the new guy and R15 was R16 stated R15 came and her cart, and the nurse knife!" and then R15 stabbed			85	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMP	LETED	
					С	
		IL6007983	B. WING		07/14/2023	
NAME OF I	PROVIDER OR SUPPLIER			27475 710 0005	1 0.,,	
NAME OF I	PROVIDER OR SUPPLIER		OME LANE	STATE, ZIP CODE		
BRIA OF	CAHOKIA		, IL 62206			
			5501/(05500 B) AN OF 665555	-		
(X4) ID PREFIX		MEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
			1	DEFICIENCY)	_	
S9999	Continued From pa	ge 8	S9999			
	·	went in his room and				
		closed. R16 stated R15				
		to the front after he stabbed				
		He (R15) was drunk. He just				
		eing out with his family."				
		and the same serving th				
	On 7/5/23 at 3:09 F	PM, V16 (Licensed Practical				
	Nurse/LPN) stated,	"I was standing right by the				
	double doors at the	nurse's station, and I heard				
arguing between (R15) and (R16). Their voices						
	were getting louder so I started walking towards					
		as going on and try to diffuse				
		hen I was within about two				
		15) pulled out the knife and				
		vith it. (R16) put his hand over room and closed the door.				
		at his side, not trying to hide				
		ing fast up the hall. I yelled				
'		fe. Call 911. He just stabbed				
		ner staff said, "No, he's armed.				
		ed with that." I went in to				
	check on (R16) and	d he was lying on his bed with				
	his hand over his le	eft side, with his shirt over it,				
		sition. He (R16) said, "I'm				
	l .	look at the wound. It was				
	l .	ers with a little bit of flesh				
		wasn't bleeding a lot by then,				
		d on his shirt and on the floor.				
	, · •	ver it and held pressure on the				
		rrived. I work for agency, and a last time I worked at this				
	ī.	some of the other staff told				
		ecall their names, (R15) went				
		and had just got back and he				
		er staff told me (R15) made the				
		t wasn't my knife. There's no				
		prints aren't on it." V16 stated				
	the other staff told	her this was unusual behavior				
		ne was usually a very nice				
	gentleman. The st	aff had called the police and				

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		С	
		IL6007983	B. WING		07/1	4/2023
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
BRIA OF	BRIA OF CAHOKIA 3354 JER CAHOKIA					
(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 pa	ige 9	S9999			:
	(DON) came in and	·				
	include: COPD, Dia Hyperglycemia, CV and Hemiplegia Aff	et documents his diagnoses to abetes Mellitus with (A (stroke) with Hemiparesis ecting the Right Non-Dominant ucinations and Schizoaffective				
	R13's MDS dated 4 and oriented.	1/18/23 documents he is alert				
	R13's Care Plan dated 3/13/17 documents: Abuse: At risk for abuse and neglect related to Schizoaffective Disorder, Depression, Auditory Hallucinations, history of behaviors and requires some assistance with care. He is noted to have a history of peer-to-peer altercations. 3/12/23 peer to peer altercation. 6/13/23 Peer to peer altercation.					
	AM documents, un reported respondin approaching, (R14) contact with him." R14 was transferre there is no serious anguish identified. are as follows: Scra	Report, dated 7/10/23 at 1:45 der Allegation Details, "Staff g to loud voices, upon stated (R13) made physical The report further documents to to ER for evaluation and bodily injury or sign of mental Injuries described in report atches, small open area. The here is no known witness at				
	documents, "Resid resident altercation separated; local po with new orders red	te, dated 7/10/23, at 4:54 AM ent initiated resident to a. Residents immediately lice notified. Physician notified beived to send to ER for ion related to physically				

PRINTED: 08/07/2023 **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: C IL6007983 B. WING 07/14/2023 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) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 10 S9999 aggressive behaviors towards peer. Behavior was not easily redirected. Staff provided 1:1 to ensure safety of patient and peers until EMS/police arrived. MD/Guardian notified. Resident going to local regional hospital. Emergency transfer discharge provided at local ER, copy provided and explained to supervisor in ER department, copy provided and explained to resident. Copy provided to resident. IDPH and ombudsman notified via email. Call placed to resident daughter/quardian with no answer, left message to return call as soon as she received message, will attempt until contact made." On 7/10/23 at 7:01 PM, V20 (Emergency Room/ER Nurse) stated R14 was brought to the emergency room by ambulance on 7/10/23 around 3:00 AM. V20 stated R14 told her another resident named (R13) had come into his room and punched him in the face several times and then stabbed him in the head with a pen. V20 stated R14 never really answered her as to whether R13 was his roommate or if he lived on the same hall as R14. V20 stated R14 had what appeared to be fresh injuries to his face and head including a black eye, a laceration to his left cheek over his cheekbone area and three puncture wounds to his scalp, two in front and one in the back of his head, and the puncture wounds had hematomas around them. V20 stated R14 had told this same resident (R13) has

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assaulted him multiple times in the past. V20 stated R14 received facial x-rays and a head Computed Tomography Scan (CT scan) to rule out facial fractures and she stated they were negative for fractures and showed the puncture wounds were superficial and did not penetrate his skull. V20 stated R14 had other injuries that appeared older, including bruises to the right side of his face, including eyebrow and cheek, upper

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		IL6007983	B. WING			4/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
	3354 JEROME LANE						
BRIA OF	CAHOKIA		, IL 62206				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
TAG	NEGOE WORLD ONE		I IAG	DEFICIENCY)			
\$9999	Continued From pa	age 11	S9999				
00000							
		nd scratches on his mid-lower					
		te fingernails. V20 stated she e facility to verify R14's report					
		ted by R13 before this. V20					
		ne facility at least a dozen					
		e would pick up the phone and					
		hout answering. V20 stated at					
		urse (V14) answered the					
		to answer any questions, and					
informed V20 she would have to talk to the Administrator. V20 stated (V1 Administrator)							
		thin a few minutes and she					
		at this was not the first time					
		R14. V20 stated V1 informed					
		een at another hospital with					
		nd stated V1 informed her R13					
		ning to the facility. V20 stated					
		13 had been on special					
		e did not know why he ow this protection plan failed.					
		i not want to return to the					
		her was his Power of Attorney,					
		ble to reach him by phone.					
		s having visual hallucinations					
	while in the emerge	ency room, responding to "his					
		hen there was no one else in			25		
	1	ted R14 was discharged back					
	to the facility that s	ame morning.					
	On 7/12/23 at 9:16	PM, during phone interview,					
	V14 (Licensed Pra-	ctical Nurse/LPN) stated she					
		se on 7/10/23 but she was the					
		d when she heard R14 yelling					
	1	e could not understand what					
		ut she ran to his room and					
	1	R14 was sitting in his 3 standing over him, and R13					
		in his head with a pen. V14					
		t R13 to stop, and he did not					
		ut finally did without her having					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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			OME LANE			
BRIA OF	CAHOKIA		, IL 62206			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	to lay hands on him. V14 stated she did not know		S9999			
	but stated he was " staff responded and	3 stabbed R14 with the pen, going at it." R14 stated other dentered R14's room and of the room and he was taken				
	ambulance arrived. why he was assault	ot on 1 on 1 until the V14 stated R13 did not say ling R14, but when the EMTs				
	(Emergency Medical Technicians), one of them reported to her that R13 stated he had assaulted R14 because R14 had thrown urine on him a month ago. V14 stated she assessed R14, and he had two puncture wounds on his head, one in front and one in back, and he also had several scratches on his face. V14 stated both R13 and					
	incident happened a there were no more	e hospital. She stated the around 1:40 AM. She stated behaviors between R13 and the facility. V14 stated she				
	R14 prior to R13 att	have any aggression towards tacking R14. She stated this s "over the top" for R13.				
	incidents when R13 prior to the incident	documents, there were two sphysically assaulted R14 on 7/10/23 and are as				
	dated 6/14/23, docu	v-up Investigation Report, uments, under "Conclusion": staff responded to loud voices,				
	upon entering room back scratcher was wasn't, he picked u	(R13) stated, "He thought the his and when I told him it p his urinal and threw his urine				
	contact with his hear	lid, I reached over and made ad. I didn't mean it, I just being thrown this way." (R14) with at him, then he got me on				
	top of the head." Sk both residents with	kin assessment completed on (R14) observed to have small ead. (R14) denied pain. (R13)				

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER;	A. BUILDING:	A. BUILDING;		LEIED
		IL6007983	B. WING		C 07/14/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		_
BRIA OF	CAHOKIA		OME LANE			
		CAHOKIA	, 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	Continued From pa	ge 13	S9999			
S9999	was immediately re enhanced monitoring complete, comprehence cannot substantiated believes situation of interviews with both without any intent a both residents agreed disagreement over belonged to." The Facility's Facility Initial Report dated documents, "Staff re (R14) making physical residence of the second seco	elocated to another room with an provided. Based on the ensive investigation, facility intention abuse and facility occurred, however based on a residents the situation was as (R13) reacted to situation, the that situation was a who the back scratcher	S9999			
	waiting for meal tra and approached (R Residents immedia notified with new or (Emergency Room) The facility's Final F	y, he moved away from table (14) making contact with face. tely separated; physician ders to send (R13) to ER () for psych evaluation."				
	the dining room at t R13 removed self f	"On 6/29/23 R13 was sitting in table during breakfast meal; rom table and approached at. R13 was placed on ng."				
	wheelchair in his ro purplish-black bruis wearing a hat with I declined to let his h stating, "No, you do fine. I'm not having happened. He's (Roame in and beat me	AM R14 was sitting in his form. R14 had small ses under both eyes. R14 was headphones over it and lead/scalp be observed, on't need to look at that. I'm grany pain. I don't know what k13) just some crazy guy who he up in the middle of the "I feel fine. I feel safe. You				

PRINTED: 08/07/2023 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: C B. WING IL6007983 07/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE **BRIA OF CAHOKIA** CAHOKIA, IL 62208 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 14 S9999 R14's Face Sheet documents his diagnoses to include Type 2 Diabetes Mellitus with Diabetic Retinopathy and Macular Edema; Acute Kidney Failure; Bipolar Disorder; HTN; History of Falls; and Schizophrenia. R14's MDS dated 3/24/23 documents he is alert and oriented. R14's Care Plan dated 4/20/22 documents: Abuse: (R14) is at risk for abuse and neglect related to impaired cognition secondary to psychiatric diagnosis. He is noted to have a court appointed guardian at this time, his brother. 6/13/23 peer to peer altercation. 3. R12's Face Sheet documents his diagnoses to include Paranoid Schizophrenia, Drug Induced Subacute Dyskinesia, Other Sexual Dysfunction Not Due to Substance or Known Physiological Condition, Anxiety Disorder, Cognitive Communication Deficit and Borderline Intellectual Functioning. R12's MDS dated 3/23/23 documents he is alert and oriented and requires supervision with his ADLs. R12's Care Plan dated 3/31/22 documents "Abuse: At risk for abuse and neglect related to his diagnosis of Depression, Schizophrenia, and Borderline Intellectual Functioning. He has been noted to ask for items of others in a way that is

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not appropriate such as "give me some of that". Has a history of peer-to-peer altercations. 6/22/23 Resident reported to stop resident who was independently propelling self down hall and ask her to suck his d***, while masturbating." R12's peer to peer altercation with R15 was not

PRINTED: 08/07/2023 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 B. WING 07/14/2023 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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 15 S9999 documented on his care plan. The Facility's Follow-up Investigation Report, dated 6/29/23, documents, under Conclusion documents "On June 22, 2023, (R2) reported as she was independently propelling her electric wheelchair down the hall upon approaching (R12's) room he asked her to stop and once she did, he asked her to suck his d*** while masturbating. (R2) immediately removed herself from the situation and reported to staff. Local police were immediately notified. Physician notified with new orders to send (R12) to ER for evaluation. Complete comprehensive investigation has been completed with facility unable to substantiate abuse. Medical record review and interviews reveal (R12) has no previous behaviors of this nature. (R2) has shown no signs of mental anguish, psychosocial distress and has maintained her usual routine with her being observed in common areas interacting with peers, attending activities of her choice. (R12) remains hospitalized." R2's MDS dated 4/19/23 documents she is alert and oriented. R2's Care Plan dated 5/28/23 documents "Abuse: (R2) is at risk for abuse and neglect related to her diagnoses of CHF (Congestive Heart Failure). history of multiple Myocardial Infarctions (MI) and

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multiple CVAs, Hypertension, COPD, decreased ability to complete all her care tasks on her own and requires assistance. Resident shared during

assessment that she has been a victim of domestic violence, addiction in the past and diagnosis of depression. History of altercations with peers. 3/27/23 peer to peer altercation.

5/28/23 peer to peer occurrence."

Illinois Department of Public Health

CTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I BAY OF GOTALESTICAL	DENTI TOATION NOWIDEN.	A. BUILDING:		COMPLETED	
	IL6007983	B. WING		C 07/14/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
BRIA OF CAHOKIA		OME LANE , IL 62206			
PREFIX (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
over to his room and while he was masturbating and she turned aroustated she got angry immediately reported of Nursing, who called was sent out of the fifthey hadn't sent (Fewould not have felt swould have been after room at night. R2 st R12's room and he reassaulted another reassaulted another reassaulted stated, "I wand when I got to his bare private area and Resident 2 (R2) was and stated that she because she was affiner. Resident 1 (R1 staff did 1 on 1 with DON notified, EMS a few hours until pict (hospital) for psychemonitor." R12's Progress Note 2023 were reviewed times R12 was note towards staff prior to abuse with R2 on 6/4. The Facility's Follows.	AM R2 stated R12 called her d asked her to suck his p**** rbating. R2 stated one other her over to his doorway while g, and she was disgusted, and and left immediately. R2 y the second time and d the incident to the Director ed the Administrator and R12 facility right away. R2 stated R12) out of the facility, she safe taking a shower, and raid he might come into her tated she never went into never came into her room. The stated 6/22/23 at 11:01 PM ent 1 (R12) verbally sexually esident. Resident 2 that was was coming down the hallway is door, he started patting his had ask me to suck his d***." It is extremely uncomfortable was afraid to lay down fraid that he would assault l12) was escorted to room; resident until EMS present. It called and said they would be lay the preport called into evaluation, will continue to the land documented four other day to be sexually inappropriate or resident-to-resident sexual	\$9999			

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: _ C B. WING IL6007983 07/14/2023 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) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 17 S9999 documented "On June 17, 2023 (R9) was standing next to (R8's) chair and was noted to have his hand resting under her shirt. Residents were immediately separated with (R9) being place on enhanced monitoring." R8's Face Sheet documents her diagnoses to include Adult Failure to Thrive, Weakness, Need for Assistance with Personal Care. Schizophrenia, Unspecified Psychosis Not Due to A Substance or Known Physiological Condition, and Alzheimer's Disease with Late Onset. R8's MDS dated 6/7/23 documents she is severely cognitively impaired. R8's Care Plan dated 10/16/19 documents, "(R8) is at risk for abuse and neglect related to her impaired cognition related to diagnosis of psychosis and past TBI (traumatic brain injury) with cognitive and safety awareness deficits. 6/12/20 Involved in an altercation with a peer." R9' Face Sheet documents his diagnoses to include Alzheimer's Disease with Early Onset: Weakness: Schizoaffective Disorder, Bipolar Type; Unspecified Dementia, Unspecified Severity without Behavioral Disturbance. Psychotic Disturbance, Mood Disturbance, and Anxiety; Major Depressive Disorder; and Alcohol Dependence with Alcohol Induced Persisting Dementia. R9's MDS dated 5/31/23 documents he is severely impaired cognitively. R9's Care Plan dated 12/12/14 documents, "(R9) is at risk for abuse and neglect related to Psychosis, Cerebral vascular Accident (CVA), Severe neuro-cognitive disorder, Affective Mood

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6007983 B. WING 07/14/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3254 IEPOME ANDE	
NAME OF PROVIDER OR SUPPLIER B. WING	23
2254 IEDOME I ANE	
BRIA OF CAHOKIA 3354 JEROME LANE	
CAHOKIA, IL 62206	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) DMPLETE DATE
S9999 Continued From page 18 S9999	
Disorder, Depression, Dementia, and GERD (Gastroesophageal Reflux Disease. He expresses resistance with care needs such as changing clothing and personal hygiene. Has a history of getting physical with others over cigarettes. Has a history of peer-to-peer altercations. 6/17/23 resident observed with his hand resting under another resident's shirt." On 7/14/23, at 10:02 AM, V1, Administrator, stated "With (R9) I did not feel the intent was there as he just had his hand resting under her shirt and they had a relationship before and were both confused so I did not substantiate it." The facility's policy, "Abuse Policy and Prevention Program 2022' dated 10/2022, documents, "This 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. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment or 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. This will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment; immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property, and implementing systems to promptly and aggressively investigate all reports	

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					(
		IL6007983	B. WING			4/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	CAHOKIA	3354 JER	OME LANE			
DIVIA	OAHONA	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999			S9999			
	misappropriation of and making necess occurrences. Resid the resident's life hi assessment, compressessments, staff increased vulnerable exploitation, mistreamisappropriation of needs, triggers and conflict. Through the will identify any protect which would reduce neglect, exploitation misappropriation of residents. Staff will and approaches on as necessary. The prevent potential abunderway. Resident another resident shit to determine the most approaches, and planer safety, as well a and employees of the facility shall take all	property and mistreatment, ary changes to prevent future ent Assessment: As part of story on the admission rehensive care plan, and MDS will identify residents with dity for abuse, neglect, atment, history of trauma or resident property, who have behaviors that might lead to be care planning process, staff olems, goals, and approaches, the chances of abuse, and instreatment, or resident property for these continue to monitor the goals a regular basis and update, facility will take steps to buse while the investigation is at who allegedly abused all be immediately evaluated bust suitable therapy, care accement, considering his or as the safety of other residents are facility. In addition, the steps necessary to ensure into including, but not limited				
llinaia Dana	tment of Public Health					

PRINTED: 08/07/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION				X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
	145613		B. WING				C 07/14/2023	
	PROVIDER OR SUPPLIER			33	REET ADDRESS, CITY, STATE, ZIP CODE 54 JEROME LANE AHOKIA, IL 62206	<u> </u>	14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	FO	000				
SS=K	2345625/IL161802 2345659/IL161835 Investigation of Fac 22, 2023; June 17, June 27, 2023/IL16 Investigation of Fac 5, 2023; June 13, 2 29, 2023/IL161442 A Partial Extended Free from Abuse at CFR(s): 483.12(a)(§483.12 Freedom f Exploitation The resident has the neglect, misappropand exploitation as includes but is not corporal punishme any physical or che treat the resident's §483.12(a) The fac §483.12(a) The fac §483.12(a)(1) Not ophysical abuse, con involuntary seclusion This REQUIREME by:	No Deficiency -F684 -No Deficiency -R600 and F610 cited -No Deficiency -F600 and F610 cited -No Deficiency -F600 and F610 cited cility Reported Incident of May 2023; June 22, 2023; and 1438-F600 and F610 cility Reported Incident of May 2023; June 25, 2023; and June -F600 and F610 Survey was conducted. Ind Neglect 1) From Abuse, Neglect, and The right to be free from abuse, Friation of resident property, Independ in this subpart. This Imited to freedom from Int, involuntary seclusion and Imical restraint not required to Imical restraint not required to Imited to medical symptoms. In the verbal mental sexual or In the right or reported punishment, or In the right of t		600			7/23/23	
_ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

07/26/2023

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145613	B. WING			07/1	4/2023	
	PROVIDER OR SUPPLIER	3		3354	EET ADDRESS, CITY, STATE, ZIP CODE JEROME LANE IOKIA, IL 62206			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 600	Based on observe review, the facility resident-to-reside 8 of 12 residents R15 and R16) revording and R15 and R16 physical abuses of head with an unk R12's head. On a the left chest with require emergency was arrested and R13 hit R14 on the later date, R13 stopen causing R14 services and R13 evaluation. The Immediate J R15 physically at head with an object R15 and R16 got altercation and R knife in R16's chew V1 (Administrato (Regional Director President of Regonal Director Presid	ation, interview, and record realied to prevent int physical and sexual abuse for (R2, R8, R9, R12, R13, R14, riewed for abuse in the sample resulted in an Immediate refollowing resident-to-resident occurred: R15 struck R12 in the nown object causing a lump to a later date, R15 stabbed R16 in a paring knife causing R16 to remains police custody; and rehead with an object and on a abbed R14 in the head with a to require emergency medical was sent out for psychiatric reopardy began on 5/5/23 when bused R12 by striking him in the rect causing a lump. On 6/25/23, rinto a verbal and physical rest. r), V2 (Director of Nursing), V5 or of Operations), and V22 (Vice relatory Compliance and Clinical report of the Immediate rest at 1:50 PM. The surveyor reversion, interview, and record report of the facility's reduced and in-service training.		600				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		145613	B. WING		07	/14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3354 JEROME LANE CAHOKIA, IL 62206		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	Continued From pa	age 2	F6	800		
	include Asthma, Dir Pain, Chronic Obst (COPD), Non-Disp Left Patella, Alcoho Gastroesophageal R15's Minimum Dadocuments he is al independent with h (ADLs). R15's Facility Incid had a resident-to-ro 5/5/23 at 1:15 PM. dated 5/5/23, docu involved in an alter and assessed. Full During the course following facts were ambulating in the chis forehead. When happened, he state (R15), had hit him hard. (R12) was a no other injuries or that (R12) had beet threatening to take of his room. (R15) resident but would used during the alt performed on both concern were remarked. The two reincidents or altercal incidents or	et documents his diagnoses to fficulty in Walking, Low Back ructive Pulmonary Disease laced Longitudinal Fracture of ol Abuse, Anemia and Reflux Disease (GERD). Ita Set (MDS) dated 3/31/23 ert and oriented and is Activities of Daily Living ent Report documented R15 esident altercation with R12 on The Facility's Incident Report, mented "Two male residents cation. Immediately separated Il investigation to follow. of the investigation, the e determined: (R12) was noted lay area with a lump noted to en (R12) was asked about what ed another male resident, in the head with something seessed and was noted with impairments. (R15) stated en coming into his room and his phone and other items out admitted he struck another not admit to the item that was ercation. Room searches were men's' rooms and all items of oved. (R15) was placed in a langement and for 15-minute men have had no further ations since the date of this the have maintained their prior at "There was no				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		E SURVEY (PLETED		
145613			B. WING	1	C 07/14/2023	
	PROVIDER OR SUPPLIER CAHOKIA		3	TREET ADDRESS, CITY, STATE, ZIP CODE 354 JEROME LANE CAHOKIA, IL 62206	<u>, </u>	
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	removed from R12' R15's Care Plan, da "Abuse: Resident is related to Chronic Consease, Unspecific Resident is an Iden history of peer-to-peresident to resident peer altercation that was not documente were no updated in resident to resident until 5/30/23. Thes resident for abuse a and quarterly. Assiste and secure en professionals. Expladjustment is often trusting relationship example, social workerbalizing thoughts the resident that stabelp, and departmed door" policy. Contin ADLs, status, and becomeseling schedulathe resident to verbanxieties, fears, con Identify areas that pummediately report injury, abuse, or characteries." R15's Care Plan Fordocuments "The residents in the resident in the resident for review."	that items of concern were and R15's rooms. ate initiated 5/30/22, document at risk for abuse and neglect obstructive Pulmonary ed, and Alcohol Abuse. Itified Offender. He has a per altercations. 6/25/23: altercation." R15's peer to to occurred on 5/5/23 with R12 ed on R15's Care Plan. There terventions after R15's altercation with R12 on 5/5/23 e interventions include Assess and neglect upon admission are resident that he/she is in a vironment with caring ain that psychosocial facilitated by developing a with another person (for riker, nurse, CNA, peer) and by a with another person (for riker, nurse, CNA, peer) and by a with another person (for riker, nurse, Establish a per with resident. Encourage alize/share thoughts, neerns, and general feelings. The with resident at risk, any episodes of unknown anges in resident's behaviors immediate intervention and	F 600			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		145613	B. WING		07	C //14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 3354 JEROME LANE CAHOKIA, IL 62206		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 600	and does not appethis time. The Illini Health performed a made a determinal He was deemed a the resident's histounlawful possession Theft/Control/Firea Assault. The resident Abuse, Uncomplicate plan include Econtrol impulses, or impulse control straddressing substatis suspected utilized testing, limit setting consequences. Relistory Analysis (Oif reasonable and a interventions includes behavior changes, and periodic reass. The facility's documents, "On 6 reported that they responding they of verbal exchange, small paring knife (R16's) left side rit in the doorway of I (R16) sustained a left rib area. Phys	admission screening process ar to present an unusual risk at ois Department of Public a Criminal History Analysis and tion regarding his level of risk. moderate risk. According to try he has been charged with on of a weapon by a felon, arm, Car Theft, and Aggravated lent has a diagnosis of Alcohol ated. Interventions for this Evaluate the resident's ability to document accordingly. Teach ategies. Follow facility protocol nate abuse. If substance abuse appropriate blood/urine g, counseling, and eview the IDPH Criminal CHA). Implement suggestions, appropriate. Moderate risk de appropriate supervision and ar monitoring, attention to visual monitoring if warranted essment." The ment, "Facility-Reported all Report" dated 6/25/23 (25/23 at 8:25 PM Staff responded to loud voices, upon observed (R15) and (R16) in (R15) then was observed with in his hand making contact with or area. The incident occurred Room (room number listed), small puncture wound to lower ician notified; new orders of ER (Emergency Room). Type		600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145613		(X2) MUL A. BUILC	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED	
		145613	B. WING		07	C //14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 3354 JEROME LANE CAHOKIA, IL 62206		71-11-2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 600	The facility's Follow dated 6/30/23, doci "Staff reported that LOA (Leave of Abstrequesting snacks made a statement placing hands on (I staff saw something swinging arm towar Residents were immeremained with (R15 (Emergency Medical escorted from facility provided pressure applied untransferred to ER (I evaluation with no streatment required, (R15) medical recombistory of Alcohol A homelessness, stra BUE (Bilateral Upper Motion) loss related medical record revilimited coping skills conflict with others, inappropriate attent with maladaptive be using loud tone who (R16) has maintain signs of mental and psychosocial distrevisualized throughous peers, attending ac asked, he states, "I ongoing, once inverted."	rup Investigation Report, uments, under Conclusion, (R15) had just returned from ence) with family, he was from staff at which time (R16) towards him resulting in (R16) R15) and giving a light push, g in (R15's) hand while rds (R16) making contact. mediately separated, staff in until police, EMS at Services) arrived with (R15) the police. Licensed nurse to left lower rib area with still EMS arrived. (R16) Emergency Room) for significant injury and/or all diagnostic testing negative. In review reveals he has a buse, history of sined family relationships and the Extremity) ROM (Range of the towakness. (R16's) the has poor social skills, which at times leads to thistory of Alcohol Abuse, the has a history of the expressing frustration. The has a history of the expressing frustration and the history of the expressing frustration and the history of the expression of the expression completed, the has a history of the has a history of the histo	F	600		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED	
		145613	B. WING	B. WING		C 07/14/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 3354 JEROME LANE CAHOKIA, IL 62206	DE	<u> </u>	-7/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION SE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 600	to left chest. Revier cough, hemoptysis, dyspnea at rest, whe pain from stab; Gastleft upper quadrant. Sequelae of penetric wall without extensing peritoneal cavity. In chest. Plan: wound Follow up with traum R16's Face Sheet of include Major Deproduced Major D	otion of Mechanism: Stabbing w of systems: Respiratory: sputum, dyspnea on exertion, leezing. Cardiovascular: chest strointestinal: abdominal pain. Chest x-ray: Impression: ating injury in the lateral chest on into the thoracic and njuries: puncture wound to left I washed out and dressed. The clinic as needed." I documents his diagnoses to essive Disorder, Cutaneous and, Osteoarthritis,	F6	800			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
		145613	B. WING		07	C /14/2023
	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE, ZIP O 3354 JEROME LANE CAHOKIA, IL 62206		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	about R16 arguing being disrespectful between the nurse yelled, "He's got a him. R16 stated it slammed the door walked up the hall him. R16 stated, came back from it. On 7/5/23 at 3:09 Nurse/LPN) stated double doors at the arguing between (were getting louds them to see what the situation, and feet from them, (Figabbed him (R16) it and went into him (R15) had the knim (R16). The own the don't get involute them to see what the situation, and feet from them, (Figabbed him (R16) it and went into him (R15) had the knim (R16). The own the don't get involute the don't get involute the fetal period in the	g with the new guy and R15 was all. R16 stated R15 came and her cart, and the nurse knife!" and then R15 stabbed are went in his room and closed. R16 stated R15 to the front after he stabbed "He (R15) was drunk. He just being out with his family." PM, V16 (Licensed Practical dt, "I was standing right by the enurse's station, and I heard R15) and (R16). Their voices are so I started walking towards was going on and try to diffuse when I was within about two R15) pulled out the knife and with it. (R16) put his hand over a room and closed the door. We at his side, not trying to hide king fast up the hall. I yelled aife. Call 911. He just stabbed ther staff said, "No, he's armed. Wed with that." I went in to and he was lying on his bed with left side, with his shirt over it, to sition. He (R16) said, "I'm be look at the wound. It was sters with a little bit of flesh to wasn't bleeding a lot by then, and on his shirt and on the floor. Over it and held pressure on the arrived. I work for agency, and and last time I worked at this at some of the other staff told me (R15) made the left staff told me (R15) made the	F 6	00		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		145613	B. WING			I	C /14/2023
	PROVIDER OR SUPPLIER CAHOKIA			STREET ADDRESS, CITY, STATE, ZII 3354 JEROME LANE CAHOKIA, IL 62206	CODE	1 011	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	E ACTION SHOULD BE D TO THE APPROPRIATE		(X5) COMPLETION DATE
F 600	statement to her, "It blood on it and my It the other staff told it for (R15) and that he gentleman. The stathe Administrator, a (DON) came in and 2. R13's Face Shee include: COPD, Dia Hyperglycemia, CV, and Hemiplegia Affe Side; Auditory Hallu Disorder. R13's MDS dated 4 and oriented. R13's Care Plan da Abuse: At risk for al Schizoaffective Disorder assistance with istory of peer-to-pet to peer altercation. altercation. The Facility's Initial AM documents, uncomported responding approaching, (R14) contact with him." TR14 was transferred there is no serious anguish identified. are as follows: Scra	t wasn't my knife. There's no prints aren't on it." V16 stated her this was unusual behavior he was usually a very nice aff had called the police and had the Director of Nursing did the report."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145613	B. WING			C 07/14/2023	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3354 JEROME LANE	IP CODE	<u> </u>	14/2023
				CAHOKIA, IL 62206			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD E	BE	(X5) COMPLETION DATE
F 600	documents, "Resideresident altercation separated; local powith new orders recepsychiatric evaluation aggressive behavious was not easily redirensure safety of patemark particles and provided and provided and punched him in then stabbed him in stated R14 never rewhether R13 was him the same hall as Rappeared to be fresincluding a black eycheek over his cheek over his cheek over his cheek assaulted him multipartical powers and the same to be stated R14 had told assaulted him multipartical powers and the same to be fresincluding a black eycheek over his cheek over his chee	ge 9 te, dated 7/10/23, at 4:54 AM ent initiated resident to . Residents immediately lice notified. Physician notified reived to send to ER for on related to physically restowards peer. Behavior ected. Staff provided 1:1 to tient and peers until. MD/Guardian notified. In an explained to supervisor in the supervisor in the supervisor in the face several times and in the head with a pen. V20 exally answered her as to its roommate or if he lived on supervisor in the superviso	F6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
///D1 D1110	N GONNEGITON	IDENTIFICATION NOMBER	A. BUILC	iING						
		145613	B. WING				I	C /14/2023		
	PROVIDER OR SUPPLIER CAHOKIA			335	REET ADDRESS, CITY, STATE, ZIP COD 4 JEROME LANE HOKIA, IL 62206	Œ	<u> </u>	14,2023		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE		
F 600	Computed Tomogra out facial fractures negative for fracture wounds were super skull. V20 stated Rappeared older, incof his face, includin left arm bruising, ar back that looked lik attempted to call that he was assault stated she called that times and someone hang it back up with about 6:00 AM a nuphone, but refused informed V20 she was Administrator. V20 returned her call with (V1) did confirm that R13 had assaulted her that she had be R13 on that night awould not be return V1 informed her R1 monitoring, and she assaulted R14 or he V20 stated R14 did facility, but his broth and they were unable V20 stated R14 was while in the emerge wife" in the room with the room. V20 stated R14 was while in the facility that sa On 7/12/23 at 9:16 V14 (Licensed Prace)	aphy Scan (CT scan) to rule and she stated they were as and showed the puncture ficial and did not penetrate his 14 had other injuries that luding bruises to the right side g eyebrow and cheek, upper nd scratches on his mid-lower e fingernails. V20 stated she e facility to verify R14's report ed by R13 before this. V20 e facility at least a dozen would pick up the phone and nout answering. V20 stated at the to answer any questions, and would have to talk to the stated (V1 Administrator) thin a few minutes and she at this was not the first time R14. V20 stated V1 informed en at another hospital with and stated V1 informed her R13 ing to the facility. V20 stated 3 had been on special edid not know why he ow this protection plan failed. Not want to return to the ner was his Power of Attorney, where the ener was his Power of Attorney, where the ener was no one else in the R14 was discharged back.	F	600						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED		
		145613	B. WING			07	C 7/14/2023	
•	NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE CAHOKIA, IL. 62206				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 600	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			00				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		DATE SURVEY COMPLETED	
		145613	B. WING			C 07/14/2023		
NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE CAHOKIA, IL. 62206					
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	(X5) COMPLETION DATE		
F 600	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 back scratcher was his and when I told him it wasn't, he picked up his urinal and threw his urine at me so when he did, I reached over and made contact with his head. I didn't mean it, I just reacted to the urine being thrown this way." (R14) stated, "Yeah, I threw it at him, then he got me on top of the head." Skin assessment completed on both residents with (R14) observed to have small scratch on top of head. (R14) denied pain. (R13) was immediately relocated to another room with enhanced monitoring provided. Based on complete, comprehensive investigation, facility cannot substantiate intention abuse and facility believes situation occurred, however based on interviews with both residents the situation was without any intent as (R13) reacted to situation, both residents agree that situation was a disagreement over who the back scratcher belonged to." The Facility's Facility Reported Incident Form, Initial Report dated 6/29/23 at 8:30 AM documents, "Staff reported (R13) approached (R14) making physical contact. Staff witnesses stated that (R13) was sitting in the dining room waiting for meal tray, he moved away from table and approached (R14) making contact with face. Residents immediately separated; physician notified with new orders to send (R13) to ER (Emergency Room) for psych evaluation." The facility's Final Report for this incident, dated 7/7/23 documents, "On 6/29/23 R13 was sitting in the dining room at table during breakfast meal; R13 removed self from table and approached R14 making contact. R13 was placed on enhanced monitoring."		Fe	600				
		AM R14 was sitting in his						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145613	B. WING			C 07/14/2023		
NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA			STREET ADDRESS, CITY, STATE, ZIP CODE 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)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	(X5) COMPLETION DATE		
F 600	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	600				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		145613				C 07/14/2023	
NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE CAHOKIA, IL 62206				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	(XS) COMPLETION DATE		
F 600	R12's Care Plan da "Abuse: At risk for a his diagnosis of De Borderline Intellectunated to ask for iter not appropriate suchas a history of pee 6/22/23 Resident rewas independently ask her to suck his R12's peer to peer a documented on his The Facility's Follow dated 6/29/23, documents "On Junshe was independe wheelchair down the (R12's) room he ask did, he asked her to masturbating. (R2) from the situation applice were immedinatified with new one evaluation. Completinvestigation has be unable to substantiar review and interview previous behaviors shown no signs of a distress and has may with her being observant or interacting with peer choice. (R12) remarks MDS dated 4/1 and oriented.	abuse and neglect related to pression, Schizophrenia, and ual Functioning. He has been ms of others in a way that is h as "give me some of that". Per-to-peer altercations. Proported to stop resident who propelling self down hall and d***, while masturbating." Paltercation with R15 was not care plan. We Investigation Report, ments, under Conclusion are 22, 2023, (R2) reported as notly propelling her electric enhall upon approaching ked her to stop and once she is suck his d*** while immediately removed herself and reported to staff. Local ately notified. Physician ders to send (R12) to ER for the comprehensive the comprehensive the comprehensive the completed with facility ate abuse. Medical record to staff. In the completed with facility ate abuse. Medical record to staff and reveal (R12) has no of this nature. (R2) has nental anguish, psychosocial aintained her usual routine rived in common areas res, attending activities of her	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	((X3) DATE SURVEY COMPLETED	
		145613	B. WING				C 1 4/2023
NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA				STREET ADDRESS, CITY, STATE, Z 3354 JEROME LANE CAHOKIA, IL 62206	IP CODE		14/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRI	3E	(X5) COMPLETION DATE
F 600	(R2) is at risk for at diagnoses of CHF (history of multiple Numultiple CVAs, Hyp ability to complete a and requires assist assessment that sh domestic violence, diagnosis of depres with peers. 3/27/23 5/28/23 peer to pee On 6/27/23 at 10:45 over to his room an while he was masturbatin and she turned arous tated she got angrimmediately reporte of Nursing, who cal was sent out of the if they hadn't sent (I would not have felt would have been al room at night. R2 s R12's room and he R12's Progress Not documents, "Reside assaulted another rassaulted stated, "I and when I got to his bare private area an Resident 2 (R2) wa and stated that she because she was a her. Resident 1 (R:	ouse and neglect related to her (Congestive Heart Failure), Myocardial Infarctions (MI) and pertension, COPD, decreased all her care tasks on her own ance. Resident shared during he has been a victim of addiction in the past and assion. History of altercations B peer to peer altercation.	F6	300			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			COM	E SURVEY MPLETED
		145613	B. WING			ı	C
NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FROM Continued From page 16 DON notified, EMS called and said they would be a few hours until pick up report called into (hospital) for psych evaluation, will continue to monitor." R12's Progress Notes for April, May and June 2023 were reviewed and documented four other times R12 was noted to be sexually inappropriate towards staff prior to resident-to-resident sexual abuse with R2 on 6/22/23. 4. The Facility's Follow-up Investigation Report, dated 6/23/23 documents, under, Conclusion documented "On June 17, 2023 (R9) was standing next to (R8's) chair and was noted to have his hand resting under her shirt. Residents were immediately separated with (R9) being					CODE	<u> </u>	14/2023
PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		N SHOULD APPROPE	8E	(X5) COMPLETION DATE
F 600	DON notified, EMS a few hours until pic (hospital) for psych monitor." R12's Progress Notice 2023 were reviewed times R12 was noted towards staff prior to abuse with R2 on 6. 4. The Facility's Fold dated 6/23/23 docud documented "On Justanding next to (Richave his hand resting were immediately splace on enhanced R8's Face Sheet do include Adult Failure for Assistance with Schizophrenia, Unsand Alzheimer's Disapple R8's MDS dated 6/2 severely cognitively R8's Care Plan date is at risk for abuse a impaired cognition in psychosis and past with cognitive and s6/12/20 Involved in R9' Face Sheet docinclude Alzheimer's	called and said they would be ck up report called into evaluation, will continue to tes for April, May and June d and documented four other ed to be sexually inappropriate to resident-to-resident sexual 1/22/23. Ilow-up Investigation Report, ments, under, Conclusion une 17, 2023 (R9) was 8's) chair and was noted to ng under her shirt. Residents eparated with (R9) being monitoring." Decuments her diagnoses to be to Thrive, Weakness, Need Personal Care, epecified Psychosis Not Due to own Physiological Condition, sease with Late Onset.	F 6				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	RIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		145613	B. WING			C 07/14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3354 JEROME LANE CAHOKIA, IL 62206		0171412020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Type; Unspecified Severity without Be Psychotic Disturba Anxiety; Major Dep Dependence with A Dementia. R9's MDS dated 56 severely impaired of R9's Care Plan data is at risk for abuse Psychosis, Cerebra Severe neuro-cogrobisorder, Depressi (Gastroesophagea expresses resistant changing clothing a history of getting placing clothing a history of getting placing clothing a history of getting placing clothing and resting under On 7/14/23, at 10:0 stated "With (R9) I there as he just has shirt and they had aboth confused so I The facility's policy Program 2022" data facility affirms the refrom abuse, neglecting misappropriation of and services by stafacility therefore prexploitation, misapmistreatment of resistance.	Dementia, Unspecified ehavioral Disturbance, nce, Mood Disturbance, and pressive Disorder; and Alcohol Alcohol Induced Persisting (31/23 documents he is cognitively. (at 12/12/14 documents, "(R9) and neglect related to al vascular Accident (CVA), nitive disorder, Affective Mood fon, Dementia, and GERD if Reflux Disease. He are with care needs such as and personal hygiene. Has a hysical with others over nistory of peer-to-peer 23 resident observed with his another resident's shirt." (a) 2 AM, V1, Administrator, did not feel the intent was d his hand resting under her a relationship before and were did not substantiate it." (a) "Abuse Policy and Prevention and the course of the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		145613	B. WING	j	ļ	07/	C 14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3354 JEROME LANE CAHOKIA, IL 62206	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 600	purpose of this politis doing all that is wo occurrences of abumisappropriation of and services by staresidents. This will environment that puresident security arimmediately protectidentified reports of exploitation, mistre of property; and impromptly and aggreand allegations of amisappropriation of and making necess occurrences. Resident's life hassessment, compassessments, staff increased vulnerable exploitation, mistre misappropriation of needs, triggers and conflict. Through the will identify any prowhich would reduce neglect, exploitation misappropriation of residents. Staff will and approaches or as necessary. The prevent potential all underway. Reside another resident shad to determine the mapproaches, and p	ent secure environment. The cy is to assure that the facility within its control to prevent use, neglect, exploitation, for property, deprivation of goods off and mistreatment of the done by establishing an aromotes resident sensitivity, and prevention of mistreatment; ting residents involved in for possible abuse, neglect, atment, and misappropriation plementing systems to essively investigate all reports abuse, neglect, exploitation, for property and mistreatment, early changes to prevent future dent Assessment: As part of istory on the admission rehensive care plan, and MDS will identify residents with allity for abuse, neglect, atment, history of trauma or for resident property, who have the behaviors that might lead to the care planning process, staff blems, goals, and approaches, as the chances of abuse,	F	600			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION			E SURVEY IPLETED
		145613	B. WING			1	C 14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 3354 JEROME LANE CAHOKIA, IL. 62206	IP CODE	, 077	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD	BE	(X5) COMPLETION DATE
F 600	facility shall take all the safety of resident to, the separation of the separation of the Immediate Jeowas removed on 7/the following actions: A. Identification of Fibe Affected: 1.R15 no longer resinto police custody of the separation of the Affected: 2.R12 no longer resided facility on 6/23/2023 3.R16 was assesse 6/26/2023 by V5 (RCare planned interviction of abuse were separated and the separated of the separated and the separated of Regular President of Regular Operations), V5, and 6.All residents will behaviors by V1, V1 be completed on 7/10/2020 and 1/10/2020	he facility. In addition, the steps necessary to ensure hts including, but not limited for residents." pardy that began on 5/5/23 12/23 when the facility took is to remove the immediacy: Residents Affected or Likely to sides in the facility, discharged on 6/25/2023. Idea in the facility, discharged on 6/25/2023. Idea in the facility, discharged in the facility, care updated by V22 (Vice tory Compliance and Clinical discharged in 7/10/2023. Reassessed for aggressive in the facility of Compliance and Clinical discharged in the facility of Compliance and Clinical discharg	F 6	600			
	7.Through the RAP	rounds (customer service					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		
		145613	B. WING				C 07/14/2023
	PROVIDER OR SUPPLIER		•	STREET ADDRI 3354 JEROME CAHOKIA, IL			0111-112-02-0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRI CH CORRECTIVE ACTION SI S-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	of abuse have beer completed Monday (Restorative Nurse), V36 (Medio Coordinator), V55 (and V17 to be initial 8. Potential admission for appropriateness (Admissions Coord Nursing). Patients aggressive behavior that identifies any paggressive behavior admission complete 9. Care plans to be needed with implement address resident spread by increasing the investigation of shall be reviewed by Management communication of shall be revi	residents, no new allegations in identified. Rap rounds to be through Friday by V37, V38 (Infection Control cal Records), V35 (Admission Business Office Manager), ted on 7/12/23 and ongoing. ons/referrals will be reviewed a for admission by V35 inator) or V2 (Director of with a documented history of ors and any background check otential risk factors for ors will not be accepted for ed 7/12/2023 and ongoing. reviewed and revised as mented interventions to be decific behavioral needs and naviors by V17, V36 and V37 investigation of abuse, in, mistreatment, or resident property occurred by the facility Quality interested in ensure that similar events do a this time, the resident specific entions will be verified in lation shall be reviewed at the lity Management committee if possible, completed on g. as held on 7/10/23 with V5, ang plan of care for R14 with I to address being a victim of	F 6	00			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING	[·····]		X3) DATE SURVEY COMPLETED	
		145613	B. WING			ı	C 14/2023	
	PROVIDER OR SUPPLIER CAHOKIA			STREET ADDRESS, CITY, STATE, ZIF 3354 JEROME LANE CAHOKIA, IL 62206	ODE -			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CX (EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD HE APPROPE	BE	(X5) COMPLETION DATE	
F 600	1.The corporate and Compliance Officer Policy and Procedu policies and proced 1-10) on 7/7/2023, emergency behavior 7/11/2023, and enhancement of compliant of the potential resident to include verification planned intervention by V22 on 7/12/202 3.V1 (Facility Admir monitor to be on du for customer service retention of staff ed hall monitor assigne 7/11/2023.	nt Occurrence/Recurrence: d leadership team V34 (Chief), V22, V33 (Vice President of re), V1, and V5 reviewed ures regarding abuse (pp 7/11/2023, and 7/12/2023, or management- code silver on anced supervision on e policy to include the ode silver for aggressive 123, pre-admission screening is, quality management review on of resident specific care ns, and protection of residents 3. histrator) will assign a hall ty 24/7 for 7 days to observe e, residents' rights, and ucation regarding abuse. 1 ed each shift, initiated on will be assigned as hall	F 6	600				
	has previously compand V56 (Previous I completed on 7/11/2 5.V1, V17 (Social S (Psychosocial Direction of the complete on the complete on 7/11/2 5.V1, V17 (Social S (Psychosocial Direction of the company of the compa	ervice Director), and V8					75	
	7/11/2023 and ongo							

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			TE SURVEY MPLETED
		145613	B. WING			I	C / 14/2023
	PROVIDER OR SUPPLIER CAHOKIA			STREET ADDRESS, CITY, STATE, ZIF 3354 JEROME LANE CAHOKIA, IL 62206	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPF	BF	(X5) COMPLETION DATE
F 600	6.The interdisciplina V17, V37, V38, V38 and V40 (Dietary M to all staff related to be completed on 7.The training will a at risk for potential manage behavior e V2, V17, V37, V38, 7/12/2023 to be ong 8.All agency staff, n available in person on the above policie behaviors prior to be and V41, Human Reongoing. 9.In the event care behavior management facilitate face to face psychiatric services or emergency transentanced supervisi return to the facility admitted for psychiatric services or emergency transentanced supervisi return to the facility admitted for psychiatric services or emergency transentanced supervisi return to the facility admitted for psychiatric services or emergency transentanced supervisi return to the facility admitted for psychiatric services or emergency transentanced supervisi return to the facility admitted for psychiatric services or emergency transentanced supervisi return to the facility admitted for psychiatric services or emergency transentanced supervision services or emergency transentanced s	ary team including V1, V2, 9 (Housekeeping Supervisor), lanager), will provide training the above-mentioned policies of 7/12/2023 and ongoing. Also include residents identified abusive behaviors and how to emergency- code silver by V1, V39, and V40 on 7/11/2023, going. The whires, and facility not or via phone will be educated est o prevent potential abusive beginning their next shift by V2 esources on 7/12/2023 to be planned interventions and tent ineffective, staff will be emergency visit with sivia in person visit, telehealth,	F6				

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		TE SURVEY MPLETED
		145613	B. WING				C /14/2023
	PROVIDER OR SUPPLIER		•	335	REET ADDRESS, CITY, STATE, ZIP CODE 4 JEROME LANE HOKIA, IL 62206	<u> </u>	114/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	12.Date Facility Ass Harm No Longer Ex Investigate/Prevent	erts Likelihood for Serious cists: 7/12/2023. Correct Alleged Violation	F 6				7/23/23
SS=E	CFR(s): 483.12(c)(2 §483.12(c) In responglect, exploitation must:	evidence that all alleged		Ů			7720720
The second secon	§483.12(c)(3) Preveneglect, exploitation investigation is in pr §483.12(c)(4) Repoinvestigations to the designated representations with States	ent further potential abuse, , or mistreatment while the ogress. It the results of all administrator or his or her ntative and to other officials in the law, including to the State					
	incident, and if the a appropriate correcting this REQUIREMEN by: Based on interview failed to substantiate when abuse occurre R12, R13, and R15) investigations in the						
	documents he is ale	rata Set, MDS, dated 3/31/23, rt and oriented and Activities of Daily Living	1	100,000			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	СОМ	E SURVEY PLETED
		145613	B. WING			I	14/2023
	PROVIDER OR SUPPLIER CAHOKIA			33	REET ADDRESS, CITY, STATE, ZIP CODE 354 JEROME LANE AHOKIA, IL 62206	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	documents "Abuse and neglect related Pulmonary Disease Abuse. Resident is has a history of pee 6/25/23: resident to The facility's documents, "On 6/2 reported that they responding they ob verbal exchange. (small paring knife in (R16's) left side rib in the doorway of R sustained a small parea. Physician no	ge 24 ate initiated 5/30/22, Resident is at risk for abuse to Chronic Obstructive Unspecified, and Alcohol an Identified Offender. He er-to-peer altercations. resident altercation." nent, "Facility-Reported I Report" dated 6/25/23 25/23 at 8:25 PM Staff esponded to loud voices, upon served (R15) and (R16) in R15) then was observed with a his hand making contact with area. The incident occurred oom (number listed). (R16) uncture wound to lower left rib tifled; new orders received to ency Room). Type of injury:	Fé	310			
	Nurse/LPN) stated, double doors at the arguing between (F were getting louder them to see what we the situation, and we feet from them, (R1 jabbed him (R16) we it and went into his (R15) had the knife it, and started walking out, "He's got a knift him (R16). The other them is the started walking the start	M V16 (Licensed Practical "I was standing right by the nurses' station, and I heard (15) and (R16). Their voices so I started walking towards as going on and try to diffuse then I was within about two (5) pulled out the knife and with it. (R16) put his hand over room and closed the door. at his side, not trying to hide ing fast up the hall. I yelled fe. Call 911. He just stabbed for staff said, "No, he's armed, ed with that." I went in to					

	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	<u> </u>		E SURVEY IPLETED
		145613	B. WING		<u></u>	ı	C 14/2023
	PROVIDER OR SUPPLIER CAHOKIA			STREET ADDRESS, CITY, 3354 JEROME LANE CAHOKIA, IL 62206	STATE, ZIP CODE	1 077	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	check on (R16) and his hand over his led lying in the fetal possibut he let me look a centimeters with a it. It wasn't bleedin blood on his shirt a gauze over it and huntil EMS arrived. was the first and later from what some or cannot recall their infamily and had just Another staff told metal to her, "It wasn't my and my prints aren's staff told her this wand that he was us The staff had called	d he was lying on his bed with eft side, with his shirt over it, sition. He (R16) said, 'I'm fine.' at the wound. It was about 1-2 little bit of flesh coming out of g a lot by then, but there was nd on the floor. I put some eld pressure on the wound I work for agency, and this st time I worked at this facility. If the other staff told me, and I hames, (R15) went out with his got back and he was drunk. There's no blood on it ton it." V16 stated the other as unusual behavior for (R15) wally a very nice gentleman. If the police and the the Director of Nursing (DON)	F	310			
	dated 6/30/23, door "Staff reported that LOA (Leave of Absorder and Staff sands on (Figure 1) and the staff sands on (Figure 1) and the swinging arm towar Residents were impremained with (R15) (Emergency Medical escorted from facilial provided pressure to pressure applied untransferred to ER (I	r-up Investigation Report, uments, under Conclusion, (R15) had just returned from ence) with family, he was from staff at which time (R16) towards him resulting in (R16) R15) and giving a light push, g in (R15's) hand while rds (R16) making contact. mediately separated, staff is until police, EMS al Services) arrived with (R15) ty by police. Licensed nurse to left lower rib area with entil EMS arrived. (R16) Emergency Room) for significant injury and/or	Table of the state				

STATEMENT AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	((X3) DATE SURVEY COMPLETED	
		145613	B. WING	3		C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 3354 JEROME LANE CAHOKIA, IL 62206	TE, ZIP CODE	07/14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD E TO THE APPROPRI IENCY)	(X5) BE COMPLETION ATE DATE	
F 610	treatment required, (R15) medical reconhistory of Alcohol Alhomelessness, stra BUE (Bilateral Upper Motion) loss related medical record revisionited coping skills conflict with others, inappropriate attent with maladaptive be using loud tone when (R16) has maintained signs of mental and psychosocial distressivisualized throughous peers, attending act asked, he states, "I'ongoing, once investable and the states of the s	all diagnostic testing negative. In review reveals he has a buse, history of sined family relationships and ex Extremity) ROM (Range of to weakness. (R16's) ew: he has poor social skills, which at times leads to History of Alcohol Abuse, ion seeking behaviors along chaviors. He has a history of en expressing frustration. ed his usual routine with no uish noted and no as noted. He continues to be sut facility interacting with civities of his choice. When m fine." Police investigation stigation completed, ent."	F6	610			
	Assistant) stated, "I had just came back asking for snacks. butter to put on his gurned the corner, hexchange in words athen (R15) stabbed here I think he is still involuntary discharge R15's Follow Up Inv 6/25/2023 documen was left unmarked, Substantiated, not vinconclusive. R15's In the Report it documents."		.5				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		145613	B. WING_		07	C 7/14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3354 JEROME LANE CAHOKIA, IL 62206	ODE	71-11-20
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 610	the allegation is ver applicable Abuse or investigation." 2. R13's June 2023 diagnoses of schizo hallucinations, and nicotine dependence R13's MDS, dated alert and oriented a Activities of Daily Li R13's Care Plan, 3/risk for abuse and reschizoaffective discontant has altercations on 3/12 R13's Facility Incide 6/13/2023 staff respentering room (R13 back scratcher was wasn't he picked up at me so when he dontact with his hear eacted to the urine stated, 'Yeah, I three top of the head.' Sk both residents with experiences auditor and has attention se had communication edentulous, per his slurred speech. Me	ified and it documents, "Not reglect did not occur per 3 POS documents R13 has paffective disorder, auditory other impulse disorders; i.e. 4/18/2023, documents R13 is and independent with his ving (ADLs). (13/17, documents, R13 is at neglect related to order, depression, auditory ory of behaviors and requires e. R13's Care Pland a history of peer-to-peer	F 61			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY
		145613	B. WING			•	C /14/2023
	PROVIDER OR SUPPLIER			335	REET ADDRESS, CITY, STATE, ZIP CODE 4 JEROME LANE HOKIA, IL 62206	1 077	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	behaviors. Resider thought process. P situation and of sm: Area has healed wi voiced no complain Based on complete facility cannot subsifacility believes situ based on interviews situation was without o situation, both rewas over who the bBoth residents have routine with neither anguish or psychos R13's Progress Not type of abuse occur R13's Facility Incide 8:30 AM, document approached (R14) rwitnesses stated the dining room waiting from table and approached in the ER (Emerger evaluation. In the instatements from the Service Director and were documented a event. On 7/13/2023 at 12 Director) stated, "Bir really do not remer (R14) did not do and	nt also has disorganized thysician was notified of all scratch to (R14's) head. thout complications; resident to f pain and or discomfort. It comprehensive investigation tantiate intention abuse and ation occurred however, is with both resident the ut any intent as (R13) reacted sidents agree that situation ack scratcher belonged to. It is maintained their usual showing any signs of mental					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION	COM	E SURVEY IPLETED
		145613	B. WING			1	14/2023
	PROVIDER OR SUPPLIER	R		3354 JE	ADDRESS, CITY, STATE, ZIP CODE ROME LANE (IA, IL 62206	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 610	there was no injury much else." R13's Abuse Investorm 6/29/2023, unverified and not such as a substance of Schisubacute dyskines due to a substance condition, anxiety communication defunctioning. R12's MDS, dated alert and oriented Activities of Daily Investors of Daily Investors. This in and visitors for foostealing from othe attempting to mas (4/1/2022). Residue haviors towards on 6/27/23 at 10:0 over to his room a while he was masturbat and she turned an stated she got angimmediately report of Nursing, who can always a substance of Nursing, who can alwa	stigation Facility Incident Report ndated, was documented as not ubstantiated. 23 POS documents R12 has zophrenia, Drug induced sia, other sexual dysfunction not e or known physiological disorder, and cognitive efficit borderline intellectual		310			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURY COMPLETE	
		145613	B. WING			C 07/14/2 0	23
	PROVIDER OR SUPPLIER CAHOKIA			STREET ADDRESS, C 3354 JEROME LANI CAHOKIA, IL 622	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE COMP	X5) PLETION ATE
F 610	if they hadn't sent F would not have felt would have been at room at night. R12's Progress Nor PM, documents, "R sexually assaulted (R2) that was assaudown the hallway a started patting his to suck his d***. R uncomfortable and lay down because sassault her. Reside room, staff did 1 on (emergency medica (Director of Nursing said they would be	R12 out of the facility, she safe taking a shower, and fraid he might come into her te, dated 6/22/2023 at 11:01 tesident 1 (R12) verbally another resident. Resident 2 talted stated 'I was coming and when I got to his door, he pare private area and ask me tesident 2 (R2) was extremely stated that she was afraid to she was afraid that he would tent 1 (R12) was escorted to a 1 with resident until EMS talted services) present. DON to notified, EMS called and a few hours until pick up, ospital) for psych evaluation,	F	510			
	6/22/2023 (R2) reprinted independently proprious the hall upon asked her to stop a suck his d*** while immediately remove and reported to staffin mediately notified orders to send (R12 R12's Investigation verified and was un R12's June 2023 Bedocumented that R towards staff. The	elling her electric wheelchair approaching (R12's) room he nd once she did her asked to masturbating. (R2) ed herself from the situation if. (Local) police were d. Physician notified with new 2) to ER (Emergency Room)." also documents it was not					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY PLETED
		145613	B. WING				14/2023
	NAME OF PROVIDER OR SUPPLIER BRIA OF CAHOKIA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 610 Continued From page 31 to perform an oral sexually act on him. On 7/5/2023 at 2:00 PM, V1 (Administrator) stated, "(R12) was not substantiated because it was a he said, she said situation and there were no witnesses so 1 could not prove anything. (R12) was served an involuntary discharge because he was sexually inappropriate with staff." R12's Medical Records document he was served Involuntary Discharge papers with the date of notice on 6/23/2023, for "the safety of individuals in the facility is endangered." 4. R9's Face Sheet documents his diagnoses to include: Alzheimer's disease with Early Onset; Weakness; Schizoaffective Disorder, Bipolar Type; Unspecified Dementia, Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety; Major Depressive Disorder; and Alcohol Dependence with Alcohol Induced Persisting Dementia. R9's MDS dated 5/31/23 documents he is severely impaired cognitively.						
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD E	3E	(X5) COMPLETION DATE
F 610	on 7/5/2023 at 2:00 stated, "(R12) was staff. The resident (R2) and (R12) was was a he said, she no witnesses so I of (R12) was served a because he was served a because he was served at least the facility is end. 4. R9's Face Sheet include: Alzheimer' Weakness; Schizon Type; Unspecified I Severity without Be Psychotic Disturbat Anxiety; Major Dependence with A Dementia. R9's MDS dated 5/severely impaired of R9's Care Plan dat is at risk for abuse Psychosis, Cerebro Severe neuro-cogn Disorder, Depressi (Gastroesophagea expresses resistant changing clothing at history of getting plants.	sexually act on him. O PM, V1 (Administrator) sexually inappropriate towards -to-resident altercation with s not substantiated because it said situation and there were could not prove anything. an involuntary discharge exually inappropriate with staff." ords document he was served rge papers with the date of 3, for "the safety of individuals angered." It documents his diagnoses to s disease with Early Onset; affective Disorder, Bipolar Dementia, Unspecified shavioral Disturbance, and aressive Disorder; and Alcohol Alcohol Induced Persisting 31/23 documents he is		10			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				E SURVEY PLETED
		145613	B. WING			1	C 14/2023
	PROVIDER OR SUPPLIER			335	REET ADDRESS, CITY, STATE, ZIP CODE 54 JEROME LANE AHOKIA, IL. 62206	1 077	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 610	altercations. 6/17/2 hand resting under The Facility Initial R documents, "Reside and with Brief Intended to have with diagnosis of Deconclusion of the R documents, "the confusion of the R documents were implemented to have I shirt. Residents were (R9) being place or Interview of witness under her shirt. I in and redirected him stayed." This invest verified/unsubstantioversight or implemented allegation is verapplicable. Abuse of investigation." On 7/14/2023 at 10 stated, "With (R9) I there as he just had aboth confused so I (R12) and (R2) there	23 resident observed with his another resident's shirt." Deport document on 6/17/2023 ent with diagnosis of dementiaview for Mental Status score or e hand under shirt of resident ementia. Police notified." Deport incident 6/17/2023 mmon area, on 6/17/2023 next to (R8's) chair and was and resting under her shirt. Inediately separated with (R9)	F6	10			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	10.00) DATE SURVEY COMPLETED	
		145613	B. WING			0 7/1	C 14/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST. 3354 JEROME LANE CAHOKIA, IL 62206	ATE, ZIP CODE	<u> </u>	7,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD E ID TO THE APPROPRI ICIENCY)	BE	(X5) COMPLETION DATE	
F 684 SS=D SO SO SO SE	because of it. (R13 If you are referring to dining room, I am not pending as well." The Abuse Policy dodocuments, "This faresidents to be free exploitation, misappedeprivation of goods mistreatment. This abuse, neglect, experience to do so, the facility resident sensitive an environment. The pressure that the facilicontrol to prevent of exploitation, misappedeprecation of good mistreatment of residents assure that the facilicontrol to prevent of exploitation, misappedeprecation of good mistreatment of residents. Sexual abute, sexual harassments assault including no non-competent to confere the conference of the conf	nvoluntary discharge papers b) is still pending police report. to the June incident in the lot sure. I believe (R9's) is still ated October 2022 acility affirms the right of our from abuse, neglect, propriation of property, s and services by staff facility therefore prohibits ploitation, misappropriation of leatment of residents. In order has attempted to establish a and resident secure furpose of this policy is to lity is doing all that is within its ccurrences of abuse, neglect, propriate of property, ds and services by staff and didents. Abuse means any njury or sexual assault dent other than by accidental use includes, but is not limited ent, sexual coercion, or sexual on-consensual or onsent sexual activity."	F 6				7/23/23	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	COM	E SURVEY MPLETED
		145613	B. WING		1	C / 14/2023
	PROVIDER OR SUPPLIER		3:	TREET ADDRESS, CITY, STATE, ZIP CODE 354 JEROME LANE AHOKIA, IL 62206	1 017	1772020
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	practice, the compressed plan, and the rather than the secondary of the compression of th	ehensive person-centered residents' choices. NT is not met as evidenced alled to provide treatments to by the physician for 3 of 4 and R4) reviewed for ample of 30. documents her diagnoses as I) Left Great Toe and Other s, Left Ankle and Foot. O AM V3 (Licensed Practical ed R1's left great toe with en applied Bacitracin-Zinc eling wound on her left great by Povidone-lodine 10% as ordered by physician. R1 my toe and put ointment on it alist Progress Note, dated s R1's wound as: Diabetic First Toe, Partial Thickness. documented the Dressing Calcium Alginate once daily daily. R1 was not seen by the her next routine visit one				

	C 14/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JEROME LANE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684 Continued From page 35 ml (10-gram total) topically to left heel. There was no clarification noted in the progress notes regarding the wound being on R1's left great toe and not her heel. R1's Treatment Administration Record (TAR) dated June 2023 documents the order for Povidone-Iodine Solution 10% to left great toe daily was discontinued after 6/4/23, but there was no order to resume this treatment order after that date. There was no order for betadine to be applied to R1's left great toe or to her left heel. This TAR also documented R1 did not receive her treatment of Bacitracin-Zinc Ointment to her left great toe on the evening of 6/17/23. There was no order for R1 to received treatment with Povidone-Iodine to her left great toe on her TAR dated July 2023 as of 7/5/23. R1's Wound Specialist Progress Note dated 7/3/23 documents R1's wound as: Diabetic Wound of the Left First Toe, Partial Thickness. The Note documented R1's Dressing Treatment Plan as: Continue Betadine twice daily; discontinue Calcium Alginate. R1's Order Summary Report dated 7/5/23 documents the Physician Order dated 6/15/23 documents the Physician Order dated 6/15/23 also documents the Physician Order dated 6/15/23 also documents the Physician Order dated 6/15/23 also documents the Order: Povidone-Iodine Solution 10%: Apply 100 millitiers (m1s.) to left great toe topically one time a day for wound healing. R1's physician orders were not updated with the new physician orders by the wound specialist on 7/5/23.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		Γ΄ 'οσ		E SURVEY IPLETED
		145613	B. WING			1	C 14/2023
	PROVIDER OR SUPPLIER			3354 JI	T ADDRESS, CITY, STATE, ZIP CODE EROME LANE PKIA, IL 62206	<u> </u>	142020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	2. R3's Face Sheet include Type 2 Dial Neuropathy, Celluli Encounter for Orth Surgical Amputation Disease, Superficial Sites, and Gangrer admitted to the fact Notes dated 2/21/2 home visit on that of the facility. R3's Wound Special 2/14/23 documents wound of the right is moderate serosal wound measurement progress note are aby 12 cm by 0.6 cm. R3's Order Summadocuments the ord discontinued 3/1/20 Dakin's (full streng every day shift for 30 days. Clean wound cover with dry R3's Minimum Data documents he is a required limited as Living (ADLs). It a surgical wound whis facility. R3's Care Plan data requires assist with bilateral amputation.	t documents his diagnoses to betes with Diabetic litis of Right Lower Limb, opedic Aftercare Following n, Peripheral Vascular al Frostbite of Unspecified ne. It documents he was ility on 1/12/23. R3's Progress 3 document he went on a date, and he did not return to alist Progress Note dated s, "He has a post-surgical foot for at least 35 days. There anguinous exudate." The ents documented on this as follows: 4 centimeters (cm) n. Pary Report dated 6/27/23 er dated 1/31/23 and 3 after R3 was discharged: th) Apply to right foot topically to promote wound healing for bund with Dakin's, apply Santyl	F6	84			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION		E SURVEY PLETED
		145613	B. WING			1	C 14/2023
	PROVIDER OR SUPPLIER CAHOKIA			3354	ET ADDRESS, CITY, STATE, ZIP CODE JEROME LANE OKIA, 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	cognitive deficits an well. Wheelchair for non-compliant at time bearing status and not using his wheelchair for the well-2/1/23 documents, pain/alteration in computation of toes diabetes and corons of peripheral neuroplaterventions for this "Administer pain meter devery day shift to produce the seaded 4x (absorbent dressing (gauze wrap). There is treatment being (Saturday), 1/22/23 (Saturday). There is progress notes or of these treatments. R3's TAR dated 2/1 (Saturday). There is progress notes or of these treatments. R3's TAR dated 2/1 (Saturday). External Stopically every day sfor 30 days. Clean is Santyl and cover with documentation of the 2/5/23 (Sunday), or 3. R4's Face Sheet	ind requires verbal cues as a mobility. (R3) is nes with his partial weight will ambulate around facility chair. R3's Care Plan dated "(R3) is at risk for infort related to recent to bilateral feet, diagnosis of ary artery disease, and history bathy and back pain. Is care plan include, edication and treatments as a care plan include, edication and treatment being done as ordered on 1/21/23 (Sunday), or 1/28/23 was no documentation in R3's in his TAR that he refused a colorion and treatment being done on 2/7/23 (Tuesday). There was no his treatment being done on 2/7/23 (Tuesday).	F 6	84			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		145613	B. WING			07/14/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3354 JEROME LANE CAHOKIA, IL 62206		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	room to provide provide provide provide dressing from R4's soiled dressing wanot been changed hand sanitized and the soiled dressing diabetic wounds, obelow the ankle, aright foot, just about had necrotic tissue V3 stated she has dressings before, aday off. She state busy and missed five yesterday. R4's Physician Ord documents an ord diabetic wound of apply betadine, cowrap with (brand in 16 days. The orded dated 6/8/23 to 6/3 heel with wound con the diabetic wound of the diabetic wound of apply betadine, cowrap with (brand in 16 days. The orded dated 6/8/23 to 6/3 heel with wound con the diabetic wound of the diabetic wound of the diabetic wound of the days. The orded dated 6/8/23 to 6/3 heel with wound con the diabetic wound of apply betadine, cowrap with (brand in the diabetic wound of the diabetic	AM V3 (LPN) went into R4's essure ulcer and diabetic. When V3 removed the gright foot diabetic ulcer, the stated 7/3/23, indicating it had the day before as ordered. V3 donned gloves and removed and R4 had two elongated one on her lateral right foot just and another on her outer lateral we the sole of her foot. Both a covering the wound bases, had to remove her own after returning from having a dothe staff must have been R4's dressing to her right foot der Summary dated 7/5/23 are dated 7/1/23, "Cleanse the right lower lateral foot, then wer with calcium alginate and lame gauze). Change daily for er previous to this order was 30/23: Cleanse wound to right leanser. Apply (brand name and name gauze) every 2 days ad). (Brand name) boots on for		84		
	dressing. Resider	n and attempted to change nt refused stating she did not All parties notified."				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	WCLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	\$A	145613	B. WING		0.	C 7/14/2023	
	PROVIDER OR SUPPLIER CAHOKIA			STREET ADDRESS, CITY, STATE, ZIP COD 3354 JEROME LANE CAHOKIA, IL 62206	E	11112020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	On 7/5/23 at 2:00 P (Administrator) atte today from R4's rigl dated 2 days ago, in changed yesterday LPN) said R4 refusitold her to put a bac regarding this." The documented for R4 wound to her right licordered on 7/2/23. treatments to be do physician. She stat document if a reside The facility's policy, Dressings, dated 1/policy of this facility clear exudates, bac debris from the wound bed completed as indicat the licensed nurse. perform wound dressed to the state of	PM, after it was brought to V1's ntion that dressing removed that lateral diabetic wound was ndicating it had not been as ordered. V1 stated, "(V10 ed her treatment yesterday. I ck dated note in R4's chartere was no explanation is treatment to her diabetic ateral foot not being done as V1 stated she would expect the as ordered by the ed the nurse should ent refuses the treatment. Wound Cleansing and 2023, documents, "It is the to cleanse all wounds and terial contamination, and and bed. Optimal wound eed until cing substances are removed it. Wound cleansing is ated in the provider's order by it is the policy of this facility to ssing changes as ordered by lean technique on all chronic	F 6	84			