STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	C 10/28/2024

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BRIA OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

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S 000	Initial Comments Complaint Investigation: #2448386/IL179379	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999		

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

These requirements were not met as evidenced by:

Based on record review and interviews the facility failed to assess and treat pain and provide pain

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medication according to physician's order for 1 of 3 (R3) resident reviewed for pain management in a sample of 11. This failure resulted in R3 experiencing severe and unbearable pain. 10/10 on pain scale of 1-10.

Findings include:

R3's Admission Record, not dated, documents Unspecified Fracture of upper end of right humerus, subsequent encounter for fracture with routine healing, Acute hematogenous osteomyelitis, left ankle foot, liver transplant failure, type 2 diabetes mellitus without complications.

R3's Baseline Care Plan, dated 10/11/2024, documents Pain: 1.Focus: B. Potential for pain 2. Goal B. Resident will verbalize or acknowledge pain when questioned by staff 3. Interventions: Administer pain medications as ordered by MD B. Monitor for non verbal indicators of pain daily with care tasks and activities C. Monitor for side effects D. Provide non pharmacological interventions (i.e. back rub, aroma therapy, ice or cold packs, etc.) Fracture 1. Focus: A. Resident has limited mobility related to fracture 3. Interventions: A. Assist with repositioning as needed B. Do not lay resident on affected side Antibiotics: 1. Focus: A. Resident is receiving antibiotic therapy 3. Interventions: A. Document s/sx (signs/symptoms) related to use of the antibiotic medication and indicate effectiveness B. Encourage fluids unless contraindicated C. Notify MD for any acute changes D. Provide medications per MD order Diabetes 1. Focus: A. Resident is at risk for hypo/hyperglycemia 3. Interventions: A. Resident blood sugar and other lab values will be within acceptable parameters according to physician through next

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review B. Accu check as ordered C. Administer medications as ordered D. Diet as ordered E. Monitor for hypoglycemia signs and symptoms: sweating, tremors, increased heart rate, confusion, slurred speech.

R3's Progress Notes, dated 10/11/2024 at 6:45 PM, documents Nurses Notes Note Text: Admit 38 yr (year) old female to rm (room) x 2 attendants. A/O (Alert and Oriented) x 3-4. Able to make needs known. Full code Diet NPO (nothing by mouth). Cont (continuous) feed Glucerna 1.5 55ml/hr (hour) (milliliters) flush. 2 assist for all transfers. Fx (fracture) to Rt (right) Humerus. No c/o pain or discomfort at this time, asking for food. Sepsis, Osteomyelitis, pneumonia, liver failure. Allergies: Clindamycin, latex, morphine, paroxetine. HR (heart rate) 65 regular. Lung sounds diminished in left upper lobe. No s/s of difficulty breathing at this time. BS (bowel sounds) + (positive) x 4 quads. Inc of B&B (bowel and bladder). 16fr Foley flowing to gravity. DVT (deep vein thrombosis) to lt (left) upper arm. PICC line in place to left upper arm. Unstageable wound to sacrum. No drsg (dressing) in place. Lt 2nd toe amputation. Resident orientated to facility, roommate and call light. Isolation precautions due to MRSA. Will follow up.

R3's Progress Notes, dated 10/12/2024 1:14 AM, documents Telehealth Visit Dysphagia--okay to change glucerna 1.5 to 1.2 until able to get new pump and feeding supplement. Patient gets 55ml/hr as continuous. Nurse cannot do NGT therefore only solution is bolus feeds. Okay for 220mL q4 x2 doses and defer further bolus feeds to NP. Concerns about BG (blood glucose) and therefore needs more BG checks while on bolus feeds.

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R3's Progress Notes, dated 10/12/2024 at 4:13 PM, documents Resident is requesting to be sent to hospital r\t (related to) severe pain 10/10.

R3's Medication Administration Record (MAR), dated 10/1/2024 to 10/31/2024, documents that R3's Levothyroxine Sodium Oral Tablet 50 MCG, Insulin NPH (Human) (Isophane) Subcutaneous Suspension 100 UNIT/ML (Insulin NPH (Human) (Isophane)), Vancomycin HCl Intravenous (Vancomycin HCl), oxycodone HCl Oral Solution 5 MG/5ML, Apixaban Oral Tablet 5 MG were not administered on 10/12/2024. No pain assessment documented in the MAR 10/11 to 10/12/2024.

R3's Controlled Drug Receipt/Record/Disposition Form, not dated, documents Date Received 10/15/2024 with first dose administered 10/16/2024 at 11:00 AM.

On 10/21/2024 at approximately 3:30 PM V2, Director of Nursing (DON), provide documents with list of medication in the convenience box. The documents list Levothyroxine Sodium Oral Tablet 50 MCG 16 available, Insulin NPH (Human) (Isophane) Subcutaneous Suspension 100 UNIT/ML (Insulin NPH (Human) (Isophane)) on hand in refrigerator, Vancomycin HCl Intravenous (Vancomycin HCl) was available for use, 10/11/2024 oxyCODONE HCl Oral Solution 5 MG/5ML (Oxycodone HCl) 5mg tablets were available for use, and Apixaban Oral Tablet 5 MG was available for use.

On 10/17/2024 at 10:45 AM R3 stated that she was admitted to the facility and within 2 days she went out to the hospital because she was not receiving care. R3 stated that the facility did not have the things she needed for her care. R3 stated that it was a mess. R3 stated that she did

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not get any medication. R3 stated that she was informed that her medication had not came in yet. R3 stated that she was in severe pain and could not get pain medication because there were none. R3 stated that she has a broken arm and her pain is horrible. R3 stated that she has ask for the pain medication. R3 stated that she has to keep the medication leveled or the pain is not tolerable. R3 stated that she had blood thinners and other medications that she had to take that were not there and she did not receive. R3 stated that she did not get her finger sticks and do not remember getting her insulin. R3 stated that the pain was unbearable. R3 stated that she just laid in the bed. R3 stated that any type of movement caused excruciating pain. R3 stated that she cried, screamed and begged but no relief. R3 stated that she takes a blood thinner, IV antibiotic, has a wound and she received none of it. R3 stated that they didn't have the feeding that she has. R3 stated that she received no care.

On 10/21/2024 at 11:45 AM V7, Licensed Practical Nurse (LPN), stated that she came to the building at around 3:00 PM (10/12/24). V7 stated that she was getting report and she heard R3 yelling that she was in pain and wanting to go to the hospital. V7 stated that this went on for a few minutes. V7 stated that she went in the room to find out what was going on. V7 stated that R3 informed her she was in pain. V7 stated that the pain was rated at a 10 on pain scale 1 to 10 with 10 being severe and unbearable. V7 stated that R3 said she haven't had any medication all day and could not handle it anymore. V7 stated that R3 did have outward signs of pain and was in visible discomfort. V7 stated that she did not get to perform a good assessment because the paramedics showed up and R3 went out. V7 stated that it happened quick. V7 stated that she

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documented what she knew and that was R3 went to hospital because of pain of 10 out of 10.

On 10/21/2024 at 11:55 AM V9, LPN, stated that she was nurse on the day that R3 was sent to the hospital. V9 stated that R3 did not have any medications. V9 stated that the previous nurse gave her an old vial of insulin and told her to use it for R3. V9 stated that R3 did have pain. V9 stated that she didn't have any facial grimacing, but she couldn't get comfortable. V9 stated that R3's medication was not there, and she gave her Tylenol. V9 stated that she was not sure of time, but it was between breakfast and lunch med pass. V9 stated that R3 was upset. V9 stated that R3 had not been evaluated by therapy and she was not allowing R3 to get out the bed. V9 stated that R3 was upset about it. V9 stated that she called about the meds because they were not delivered. V9 stated that there was a problem with the medication and had to be straightened out. V9 stated that she left at 3 pm and the medication was not there. V9 stated that R3 was crying and upset saying she was in pain. V9 stated that the oncoming nurse took care of it. V9 stated that she was later told that the facility had a (emergency medication system convenience box) and that she should have gotten the medications out of it. V9 stated that she is agency, and this was never told to her and that she was not aware that the facility had a (emergency medication system convenience box).

On 10/21/2024 at approximately 3:30 PM V2, DON, stated that the facility has a (emergency medication system-convenience box) and when medication is not delivered than the nurses can use the medication from the (emergency medication system convenience box). V2 stated

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that he expects his staff to utilize the (emergency medication system convenience box) when medication is not available and call the pharmacy to check when medication will be delivered and notify the physician if necessary.

The facility's Pain Management policy, dated 10/2023, documents General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence and enhance dignity and life involvement. Guideline: The pain management program is based on a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Policy: 2. Pain will be assessed at least once every shift and documented in the EMAR using the pain scale appropriate for the patient.

(B)