STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057349	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF MASCOUTAH	901 NORTH TENTH STREET , MASCOUTAH, Illinois, 62258

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S0000	Initial Comments Complaint Investigations 2547662/2589440 2547650/2589453	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2) 300.1620a) 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 and psychosocial needs that are identified in	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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. 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. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to properly clean an indwelling urinary catheter, failed to complete and document indwelling catheter care as ordered, failed to verify an indwelling urinary catheter flush order, failed to monitor intake and output as ordered, and failed to ensure a resident’s indwelling was properly positioned	S9999		

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S9999	Continued from page 2 and covered for 3 of 3 residents (R1, R2, R5) reviewed for indwelling urinary catheters in the sample of 11. These failures caused R2 to experience increased pain and sepsis secondary to developing a catheter associated urinary tract infection. Findings Include: 1. R2's Admission Record document, print date of 8/18/25, documented R2 was a 52-year-old male initially admitted to the facility on 6/30/25 with diagnoses including Wernicke's encephalopathy, type 2 diabetes mellitus, chronic gout, insomnia, alcohol abuse, major depressive disorder, polyneuropathy, hypertension, and obstructive and reflux uropathy. R2's MDS, dated 7/14/25, documented R2 was severely cognitively impaired, dependent on staff for toileting and hygiene needs, and had an indwelling urinary catheter. R2's care plan, initiation date of 6/30/25, documented R2 required use of an indwelling catheter related to obstructive uropathy and was at risk of infection. Care plan interventions include monitor for s/s (signs/symptoms) of UTI (urinary tract infection), notify MD (Medical Doctor) of abnormal findings, staff to monitor patency of catheter, and record output as directed. R2's care plan did not address indwelling catheter care although R2's admission orders, dated 6/30/25, documented indwelling catheter care every shift as needed. R2's TAR (Treatment Administration Record), dated 7/2025, documented an order for indwelling catheter care every shift as needed. This TAR did not document R2's catheter care was completed at all on 7/2/25 nor was it completed on every shift as ordered on 7/11/25, 7/21/25, nor 7/23/25. This TAR documented monitor urine for infection q (every) shift. This TAR did not document this was completed on 7/2/25. This TAR also documented monitor (indwelling urinary catheter) placement q shift. This TAR does not document it was completed every shift on 7/2/25, 7/6/25, 7/10/25, 7/12/25, 7/21/25, nor on 7/23/25. R2's TAR, dated 8/2025, does not document R2's catheter care was completed every shift as ordered on 8/8/25. R2's progress note authored by V12 Nurse Practitioner, dated 7/1/25, documented obstructive and reflux uropathy, unspecified, continue (indwelling catheter) care and management. Monitor I&O (intake and output).	S9999		

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S9999	Continued from page 3 R2's catheter output record, dated 7/1/25, did not document any output on 7/1/25, nor did it document R2's urinary output was completed every shift on 7/6/25, 7/8/25, 7/10/25, 7/12/25, 7/13/25, 7/14/25, nor on 7/15/25. R2's output record, print date of 8/20/25, does not document R2's urine output was monitored every shift as ordered on 7/22/25, 7/30/25, 7/31/25, 8/1/25, 8/3/25, 8/5/25, 8/6/25, 8/7/25, nor 8/10/25. R2's fluid intake records for July and August of 2025 are not documented every shift as ordered on 7/1/25, 7/2/25, 7/6/25, 7/8/25, 7/10/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/18/25, 7/21/25, 7/30/25, 7/31/25, 8/1/25, 8/4/25, 8/5/25, 8/6/25, 8/8/25, and 8/10/25. R2's progress notes, dated 7/3/25, documented at 4 PM while assisting CNA (Certified Nurse Assistant) noted urine in drainage bag to have the appearance of thin beige liquid. (R2's Facily) states she "would like this to be expedited." Call placed to NP (Nurse Practitioner) at 4:40 PM, received order to send out to ER (Emergency Room) if family desired. At 4:50 PM, family stated they would like him sent to ER. R2's hospital discharge summary, dated 7/5/25, documented R2 was hospitalized with severe sepsis secondary to CAUTI (catheter associated urinary tract infection). Suspect (indwelling urinary catheter) was dislodged or clogged as patient had immediate large volume output with new (indwelling urinary catheter) placement. R2's hospital discharge orders, dated 7/5/25, documented an order to flush R2's indwelling urinary catheter with 30 ML NS (normal saline) BID (two times per day). R2's facility progress note, dated 7/5/25 at 5:55 PM, documented resident returned to the facility by way of (local) EMS (emergency medical service) in company of (R2's Family). Resident is alert and oriented x 1-2, (indwelling urinary) catheter in place draining yellow urine with small amount of sediment noted in the tubing. New orders for amoxicillin 500 mg PO (by mouth) every 12 hours for 7 days and Keflex 500 mg PO 3 times daily for 10 days. Instructions to flush (indwelling urinary) catheter with 30 ml of saline every 12 hours. R2's MAR (Medication Administration Record), dated 7/2025, documented an order, dated 7/5/25, to flush R2's indwelling urinary catheter with 30 CC H20 (water) Q 12 hours. This MAR documented R2's indwelling urinary	S9999		

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S9999	Continued from page 4 catheter was flushed with 30 CC H20 Q 12 hours twice a day from 7/7/25 through 7/31/25. On 8/18/25 at 1:55 PM V3 LPN/CPC (Licensed Practical Nurse/Care Plan Coordinator) stated she completed the admission for R2 on 7/5/25, the indwelling catheter flush order didn't specify what it should be flush with. V4 stated she put the order in as water. Surveyor asked V4 what kind of water was used for the flushes and V4 replied tap water. Surveyor requested that order. On 8/18/25 at 2:04 PM V3 came to surveyor and stated I know where that water order came from, it was from the R2's urologist on 8/4/25. V4 presented the order, the order documents catheter flushing every 8 hours. The order does not specify what to flush with. R2's progress note, dated 8/4/25 at 9:27 AM, documented left facility for appointment with urologist. Accompanied by (R2's Family) and CNA (Certified Nurse Assistant). R2's after visit summary from R2's urologist, dated 8/4/25 at 10 AM, documented orders for topical antibiotics around the tip of R2's penis and indwelling urinary catheter flushing every 8 hours. R2's progress note, dated 8/4/25 at 1:18 PM, documented returned to facility at this time. No changes in orders. R2's progress notes do not document the orders to increase R2's indwelling urinary catheter flush to every 8 hours, no documentation of any facility nursing staff calling R2's physicians for clarification of what to flush R2's catheter with, nor does it document a topical antibiotic was ordered for R2's penis pain and infection. On 8/18/25 at 8:06 AM V11, (R2's Family), stated she did inform R2's nurse of R2's new orders from his urologist for topical antibiotics and to increase R2's indwelling urinary catheter to every 8 hours from every 12 hours. V11 stated she provided the facility nurse with a copy of the orders. V11 stated she had a care plan meeting with the facility staff on 8/5/25 to discuss a very long list of issues and she brought up the catheter flush upgrade to every 8 hours as well as the topical antibiotic and R2's reporting of pain at his penis. V11 stated when she visited R2 on 8/8/25 and R2 once again told her the tip of his penis hurt. V11 stated she approached the nurse's station to check on R2's topical antibiotic order and found the facility had never implemented R2's topical antibiotic order.	S9999		

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S9999	Continued from page 5 R2's August 2025 MAR documented R2's topical antibiotic bacitracin was not implemented until 8/9/25. This MAR documented flush (indwelling urinary) catheter with 30 cc H20 Q 8 hours for UTI. This was ordered on 8/4/25 by R2's urologist although it was not implemented until 8/5/25 at 4 PM. R2's progress notes do not document any physician notification to clarify what R2's indwelling urinary catheter should be flushed with. R2's Medication Review Report documented R2 had a physician order, dated 7/16/25, for (indwelling urinary catheter) and bag, change monthly and as needed 16 FR (French) with 10 cc balloon. R2's progress note, dated 8/5/25 at 2:22 PM, documented (indwelling urinary) catheter leaking, scant amount of cloudy amber urine in tubing. Bulb deflated, and (indwelling urinary catheter) removed. New #16 FR indwelling catheter inserted with 30 ml normal saline. R2's medical record did not document any orders for a size 16 FR with 30 ml bulb. R2's progress note, dated 8/6/25 at 8:35 AM, documented care plan meeting, met with the whole family and most of the department heads. It continues, we went over his urology appt (appointment) wants his (indwelling catheter) flushed every 8 hours instead of 12. R2's progress note, dated 8/12/25 at 7:15 AM, documented nursing notified provider that resident had a fall early this am where he slid from his bed to the floor. Post fall BP (blood pressure) was 70s/60s. Additionally, labs that resulted overnight revealed WBC (white blood cell) was critical high at 38k (38,000), with elevated procalcitonin level as well. Gave order to send resident to ED (emergency department) d/t suspected septic shock. R2's critical care medicine history and physical note, dated 8/12/25, documented septic shock, etiology likely secondary to PNA (pneumonia) vs CAUTI. (Indwelling catheter) replaced in ED due to leaking around cuff on 8/12. 2L urine output returned. 2. R1's Admission Record, print date of 8/18/25, documented R1 has diagnoses including rheumatoid arthritis, malnutrition, chronic fatigue, heart failure, altered mental status, neuromuscular dysfunction of bladder, cognitive communication deficit, hypertension, and acquired absence of right shoulder. R1's MDS (Minimum Data Set), dated 7/11/25, documented R1 is moderately cognitively impaired.	S9999		

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S9999	Continued from page 6 R1's care plan, undated, documented R1 has an (indwelling urinary catheter) related to neurogenic bladder and is at risk of infection. Interventions include keep drain bag covered to promote privacy. R1's care plan does not address catheter care. R1's physician orders, dated 7/24/25, documented monitor for foley catheter position and placement every shift, intake and output every shift, and catheter care every shift. R1's August 2025 TAR (Treatment Administration Record) did not document R1's indwelling urinary catheter care was completed on the day shift on 8/15/25, evening shift on 8/7/25, 8/8/25, nor 8/15/25, nor on the night shift on 8/8/25. R1's August 2025 TAR documented monitor for (indwelling urinary catheter) position and placement q (every) shift. This TAR does not document this as completed on the day shift of 8/15/25, evening shift on 8/7/25, 8/8/25, nor on 8/15/25, nor on the night shift of 8/8/25. R1's urinary output record, print date of 8/20/25, does not document R1's urine output was documented every shift on 8/7/25, 8/8/25, 8/10/25, 8/12/25, 8/13/25, 8/15/25, nor on 8/17/25. On 8/20/25 at 12:27 PM V1 Administrator provided intake stated she could not find any intake records for R1 for July nor August 2025. On 8/18/25 at 8:38 AM R1 was observed in bed with her breakfast in front of her. R1's indwelling urinary catheter bag was uncovered and lying directly on the floor under the bed. V3 Care Plan Coordinator/LPN (Licensed Practical Nurse) walked in and stated to R1 "where is your catheter bag?" V3 then picked the catheter bag up off the floor, placed the bag in the bag cover, and attached it to R1's bed. 3. R5's Admission Record document, print date of 8/18/25, documented R5 has diagnoses including multiple myeloma, ataxia following nontraumatic intracranial hemorrhage, polyneuropathy, glaucoma, hypertension, benign prostatic hyperplasia, and obstructive and reflux uropathy. R5's MDS, dated 7/28/25, documented R5 is moderately cognitively impaired although at time of interviews R5 was alert and oriented.	S9999		

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S9999	Continued from page 7 R5's care plan, undated, documented R5 is at risk for complications related to receiving chemotherapy, R5 requires use of an indwelling catheter related to obstructive uropathy and is at risk of infection, and R5 requires enhanced barrier precautions (EBP) related to indwelling medical device. R5's care plan interventions include staff to wear gown and gloves when performing ADL's (activities of daily living) including when providing hygiene care. R5's physician orders, print date of 8/18/25, documented orders for enhanced barrier precautions for indwelling medical device urinary catheter, indwelling catheter care every shift as needed, and I & O (intake and output) q shift. On 8/18/25 at 8:40 AM surveyor asked R5 how often the nurses and CNAs clean around his catheter. R5 replied not very often, I can't remember the last time they cleaned it. On 8/18/25 at 11:02 AM V6 CNA and V9 CNA were observed as they provided indwelling urinary catheter care for R5. V6 and V9 had the clean supplies set up on a bedside table covered with a clean towel although the clean gloves were off to the side of the towel and directly on the bedside table. R5's door to his room is clearly marked with enhanced precautions signs and PPE (personal protective equipment) including gowns was readily available on the isolation door supply caddy. Neither V6 nor V9 donned gowns at any time during this observation. V9 cleansed R5's penis, scrotum, and inner thighs but did not cleanse R5's indwelling catheter tubing. V6 and V9 rolled R5 onto his right side without repositioning the catheter bag or tubing causing the urine to back flow in the tubing. R5's 8/25 TAR documented (indwelling urinary) catheter care every shift as need although it was not documented as completed every shift on 8/7/25, 8/8/25, nor 8/15/25. R5's catheter output record, print date of 8/20/25, did not document R5's urine output was monitored every shift on 7/22/25, 7/23/25, 7/27/25, 7/28/25, 7/29/25, 8/2/25, 8/3/25, 8/4/25, 8/5/25, 8/7/25, 8/8/25, 8/10/25, 8/12/25, 8/13/25, 8/15/25, 8/16/25, nor 8/17/25. R5's fluid intake records for July and August of 2025 do not document R5's intake was recorded every shift as ordered on 7/17/25, 7/19/25, 7/23/25, 7/26/25, 7/27/25, 7/31/25, 8/1/25, 8/2/25, 8/3/25, 8/6/25, 8/7/25, 8/10/25, 8/12/25, nor 8/15/25.	S9999		

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S9999	Continued from page 8 On 8/20/25 at 11:07 AM V2, DON, and V15, ADON were interviewed. V2 stated she would expect the CNAs to don (put on) gowns and cleanse the indwelling catheter tubing while providing catheter care. V15 stated she expects the CNAs to reposition the urinary catheter tubing and bag during turning and repositioning to prevent the urine from back flowing. V2 stated she and the other nurses did not view R2's urologist's instructions on 8/4/25 as physician orders therefore they were not clarified nor implemented. V15 stated she did not view them as orders either. V15 stated she would expect the CNAs and nurses to complete and document catheter care and I&Os as ordered. The facility's (Indwelling) Catheter Care policy, dated 4/2019, documented Policy: Daily and PRN catheter care will be done to promote comfort and cleanliness. Equipment: The following equipment and supplies will be necessary when giving catheter care: 1. Basin with warm water and soap/or pre-moistened disposable cloths. 2. Personal protective equipment (i.e. gowns, gloves, etc.) as necessary. 3. Towel and washcloth. 4. Protective bed pad. Procedure: 1. Wash your hands before beginning the procedure. 2. Assemble all equipment and supplies that will be necessary to perform the procedure. 3. Knock before entering the room. 4. Arrange the supplies so they can be easily reached. 5. Identify yourself. Explain procedure to resident. It continues, 11. Cleanse area of catheter insertion site, using soap and water or pre-moistened wipes. 12. Wash catheter itself by holding on to catheter at insertion site, wash with one stroke downward, using same procedure for rinsing. The facility's Intake and Output policy, dated 6/2015, documented General: Intake and/or output are monitored accurately to ensure adequate fluid balance for residents. Responsible Party: all nursing staff. Guideline: 1. All staff can record the intake or output in the resident record. 2. Intake is recorded for residents with the following: a. Fluid restriction, b. IV therapy, c. Tube feedings, d. Order. 3. Output is recorded for residents with the following: a. (indwelling) catheter, b. Suprapubic catheters c. Order. (A)	S9999		