STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048645	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

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

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S0000	Initial Comments Complaint Investigation: #2548043/IL2597542	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure	S9999		

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

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S9999	Continued from page 1 that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review the facility failed to properly assess and supervise a resident during an out of state physician's appointment for 1 of 4 residents (R2) reviewed for supervision in a sample of 16. This failure resulted in R2 who is known of returning from day passes intoxicated, not returning to the facility on 08/19/25 directly after the appointment with non-emergency ambulance transportation provider or staff escort and instead returning on public transportation after going sightseeing. Findings Include: R2's Admission Sheet, admission date of 11/20/24, documented R2 has diagnoses of but not limited to spinal stenosis, major depressive disorder, repeated falls, other psychoactive substance abuse, alcohol use, unspecified with intoxication. R2's Minimum Data Set (MDS), dated 07/01/25, documented R2 is cognitively intact with a Brief Interview of Mental Status (BIMS) of 15 out of 15 and he requires supervision or touching assistance with some of his activities of daily living (ADLs). R2's Care Plan, admission date of 11/20/24, documented ABUSE: R2 is at risk for abuse and neglect related to (r/t) polyneuropathy, alcohol abuse, major depression, malnutrition, and spinal stenosis. Resident prefers to go on appointments alone (revision date 08/28/25). Goals: Staff will monitor well-being of others. Resident will have zero episodes of abuse and neglect throughout next review. Interventions include but not limited to Assure resident that he/she is in a safe and secure environment with caring professionals. Explain that psychosocial adjustment is often facilitated by developing a trusting relationship with another person (i.e., social worker, nurse, CNA, peer) and by verbalizing thoughts, needs and feelings, identify areas that put resident at risk. Review assessment information. Emphasize treatment of casual factors and/or interventions designed to	S9999		

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S9999	Continued from page 2 moderate/reduce symptoms (make treatment of compulsive behavior, substance abuse, anger and mental health issues available to the resident, as indicated). It also documented R2 has a history of trauma related to being beat up in the community, and homeless. Some intervention includes but not limited to provide a safe and supportive environment. R2's care plan further documented R2 is at risk for injury related to impaired coordination, impaired judgment, and altered level of consciousness dur to alcohol intoxication. Goal Resident will remain safe and free from injury during and after the episode of intoxication. Intervention: Implement fall precautions (bed alarm, non-slip footwear, frequent rounding). R2's Elopement Evaluation, dated 11/20/24 at 5:03 PM, documented R2 had a score of 16 which is high risk for elopement. R2's Elopement Evaluation, dated 03/27/25 at 3:46 PM, documented R2 had a score of 2 which is no risk for elopement. The facility's Release of Responsibility for Leave of Absence dated 04/02/25, documented R2 was signed out of the facility by V5 (R2's Friend) at 2:46 PM and wasn't signed back into the facility until 04/03/25 at 10:06 PM. The facility's Release of Responsibility for Leave of Absence dated 04/15/25, documented R2 was signed out of the facility by V5 at 10:25 AM and was then signed back into the facility on 04/16/25 at 6:23 PM. R2's Progress Notes, effective date: 04/16/25 at 5:25 PM (created date: 04/16/25 at 10:27 PM), documented Resident called facility and stated that he will be arriving back to facility within a couple of hours. R2's Progress Notes, effective date: 04/16/25 at 6:23 PM (created date: 04/17/25 at 7:49 AM), documented Resident returned to facility via friend vehicle. Remains stable at this time. No signs of distress noted at this time. R2's Progress Notes, dated 6/15/2025 at 5:43 PM, documented Note Text: Resident returned from leave of	S9999		

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S9999	Continued from page 3 absence (LOA), he appeared intoxicated and smelled like liquor. Resident gait is unsteady, alert with slurred speech. VS (vital signs) 97.8-82-20-92/60 sats 94% on RA (room air). Respirations even and unlabored. No s/s (signs/symptoms) of distress. Staff will monitor q (every) 15 min (minutes). Evening medications held. Resident now resting quietly in bed. NP (Nurse Practitioner) aware. Will continue to monitor. R2's Progress Notes, dated 6/15/2025 at 8:12 PM, documented Note Text: Resting in bed. Continues q 15min checks. Appetite good. Po (by mouth) fluids encouraged. Alert with decrease in slurred speech. No s/s of distress. Will continue to monitor. R2's Progress Notes, dated 6/16/2025 at 09:17 AM, documented Social Service Note: Spoke with resident in regard to accusations made by staff. Resident denied accusations stating he left the building on LOA between 9-10am and was out with his friend all day until around 5:30pm. Resident stated he did not sign back in at 2:30pm he did not get back to the facility until 5:30pm. Resident agreed to a behavior contract in regard to following the facility policies. R2's Behavior Contract, dated 06/16/25, documented R2 was placed on a behavior contract as an intervention to his treatment plan and in an attempt to maintain his safety, and well-being during his stay at the facility. He agreed to the following: Refrain from going out on LOA and returning to the facility intoxicated. R2's Elopement Evaluation, dated 06/16/25 at 10:43 AM, documented R2 had a score of 41 and is considered a high risk for elopement. The facility's Release of Responsibility for Leave of Absence dated 08/12/25, documented R2 left the facility with V5, R2's friend at 5:05 PM and the log says he was back at 12:48 AM on 08/13/25 but the Nurses notes said he didn't return until 7:53 AM. R2's Progress Notes, dated 8/12/2025 at 5:18 PM, documented Note Text: Resident going out LOA at this time without meds with plans to return in a few hours. Resident informed to notify staff upon return.	S9999		

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S9999	Continued from page 4 R2's Progress Notes, dated 8/13/2025 at 07:53 AM, documented Nurses Notes Resident returned no sign/symptoms (s/s) of discomfort and no new skin issues. The facility's Release of Responsibility for Leave of Absence dated 08/15/25, documented R2 left the facility with V5 at 10:00 AM and returned to the facility at 5:35 PM. Nurses note said he appeared intoxicated. R2's Progress Notes, dated 8/15/2025 at 6:08 PM, documented Note Text: Resident came back LOA appeared intoxicated. spoke with Physician who said to hold narcotics and Psychotics just for tonight. Make sure blood pressure is taken before administering meds no blood thinners. Resident resting in bed call light in reach. On 8/15/2025 7:28 PM, Acute Care Note, documented Patient returned to facility from LOA with family patient mediation held due to nursing staff reporting patient observed with slurred speech and unsteady gait. patient approached by staff with reports of strong odor of alcohol on breath Patient admitted to consuming alcohol off site prior to return to facility. No chest pain or dizziness reported. No nausea or vomiting noted. History of Present Illness: This is a 55-year-old male admitted to the facility on 11/20/24 with a primary dx (diagnosis) of multiple falls, patient had multiple witnessed falls by bystanders, with at least one fall involving head trauma. In the ED (Emergency Department) patient was made code stroke status on arrival. CT (Computed Tomography scan) head negative for stroke or hemorrhage. Stroke team recommended no TNK (Tenecteplase). Patient was hypertensive to 165/104 with HR (Heart Rate) 113. R2's Electronic Medical Record (EMR) was reviewed and had no documented time of when R2 left for his appointment or documented time of when he returned to the facility from his appointment. R2's EMR had three prescriptions from the out-of-town appointment, dated 08/19/25 at 10:33 AM, and documented he was to start on Gabapentin 300 milligrams (mg) take on capsule three times a day, Camphor-menthol 0.5-0.5% lotion, apply to affected area three times daily as needed for itching, and Kenalog 0.1% cream, apply to affected areas twice daily as needed for itch.	S9999		

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S9999	Continued from page 5 On 08/27/25 at 11:15 AM, V3, Activities Aide said the incident happened sometime last week she isn't sure of the dated. She said R3 went out to a doctor's appointment by himself and when transportation went to go and pick him up, he wasn't there. She said V1 and two other staff went to look for him and they found him down on state street and he was drunk. V3 said transportation called up to the facility and asked if R3 was back yet and they told them no. She said that's why residents aren't allowed to go by themselves on appointments now someone must go with them. On 08/28/25 at 9:15 AM, R2 said when he goes on appointments the facility will take him in the van or they will have a med car or uber take him sometimes. R2 said after his doctor's appointment on the 19th (August) he was supposed to call the driver of the car service, and the driver would come back and get him, but he didn't do that. He said he found an adventure pass for the bus, so he used it to come back to the facility. He said he wanted to just go sight-seeing, and he returned to the facility about 2:00 PM or 3:00 PM at afternoon. R2 said the time he was found on State/25th street was a different time. He said V5, (R2's friend), had signed him out and he had slipped away from V5 because V5 was being a little irresponsible. R2 said the facility had then called V5 to track him down because V5 would know where to find him. He said V5 found him on 25th street after he spent the night there. R2 said when he is out, he will have a cigarette and a beer sometimes. On 08/28/25 at 11:37 AM, V5, (R2's friend) said on one incident the facility called him and asked if he knew where R2 was at. He said I know where he hangs out, so I went and found him and took him back to the facility. V5 said he did not stay with him that night and he doesn't know where he stayed. V5 said that was the first time R2 had left him like that. V5 said R2 use to work down on 25th street so he knows a lot of people from that area. On 09/02/25 at 11:10 AM, V7, Transportation stated when someone has an appointment, he is the one who makes up all of the resident packets that is sent with them and he is also the one who calls and makes the arrangements for the resident's rides to and from the appointments. He said with R2 he called the insurance company and gave them the information regarding the appointment.	S9999		

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S9999	Continued from page 6 The insurance company then will put it out there for someone to pick it up. V7 said he knows on the day of R2's appointment it was A- One med care that picked R2 up from the facility. He said R2 had an envelope with all of information in it and on the back of the envelope was the phone number of the facility and of the car service. V7 said R2 was to either call the car service or he could call the facility to let them know he was done with his appointment and the facility would then call the car service and let them know he was ready to be picked up. V7 said when you call to inform the car service you are ready to be picked up it can take them up to an hour to come and get you. V7 said on this day R2 didn't call the facility or the car service to let them know he was ready to be picked up. He said the car service then called the facility and asked them if they had heard from R2 because it was getting close to time for him to quit for the day and he hadn't heard from R2. The facility told him they haven't seen R2 and that he wasn't at the facility at that time. V7 said he believes Illinois Department of Public Health (IDPH) was in the facility at the time this all happened. He said some of the staff went over to the doctor's office where R2 had his appointment and were looking for him and he wasn't there. V7, he doesn't believe R2 returned with the staff when they came back either. He said this has happened on several occasions and they haven't been documenting on it. V7 said he know for a fact that on this day V8, Receptionist was on and off the phone with the car service regarding R2. On 09/02/25 at 12:48 PM, V11, (med car transport) said he was the person who took R2 to his doctor's appointment in St. Louis. He said he dropped R2 off at the appointment and just kind of waited around for R2 to get a hold of him after he was done with the appointment, but he never contacted him. He said it was getting late and close to the end of his shift for the day, so he called the facility and checked to see if R2 was there. He said he talked with V8 at the facility and she called the doctor's office and was on hold for 30 minutes and while she was on hold R2 came walking in the doors. V11 said they don't know how he made it home he just showed up. On 09/02/25 at 1:23 PM, V9, Primary Care Physician said R2's baseline is he is cognitively intact with a BIMS of 15 so he can make sound decisions. As for when he is drinking is anybody capable of making sound decisions. V9 said they should always monitor and make sure the resident is okay while they are intoxicated. He said they have policies in place for that to determine their	S9999		

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S9999	Continued from page 7 cognition. V9 said if he would expect the facility to assess the resident at that point and time and monitor their alcohol use. It's kind of bordering on resident rights. He would also expect them to make an on-the-spot assessment to determine if they are cognitively impaired in anyway. On 09/02/25 at 1:45 PM, V8, Receptionist said she let R2 know when he was done with his appointment to contact the facility, and they would call the ride company and send them to get him. She said R2 never did contact the facility, and the car company called the facility asking if they knew where R2 was. She said the car company was closing early that day, and they still hadn't heard from R2, and he was calling to check about him. V8 said she did try and contact the doctor's office regarding R2, but she could never get through to anyone and she was on the phone waiting for over a half an hour. She said she was on hold until after 1 PM. She said that was when she informed them (facility staff) here about R2. V8 said he did come in the front door during this time, but she isn't sure how he got here to the facility. She said she was busy working the desk and didn't see how he got here. On 09/02/25 at 2:40 PM, V12, Licensed Practical Nurse (LPN) said when someone goes on an appointment, they usually send someone with that person, and she doesn't know why he (R2) didn't have someone with him. V12 said no she doesn't feel like R2 is able to make safe decisions at all. She said he wouldn't be here if he was. He's here for a reason. V12 said she has seen R2 here at the facility intoxicated. On 09/02/25 at 2:45 PM, V13, LPN said she usually isn't R2's nurse that she always works on a different hall when she works. She said she heard about R2 and what happened but that's it. She said they usually have someone with them when they go out on an appointment. She doesn't feel R2 is safe to make sound decisions at all. On 09/03/25 at 1:40 PM, V17, Certified Nursing Assistant (CNA) said 25th and State Street is a busy street, and a lot of people hang out there. She said it depends on what you get yourself into, but that street can be rough. V17 said about six to eight months ago a restaurant located on that street had an employee who was shot and fatally wounded while at work and it was shut down for about three weeks. She said there is a	S9999		

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S9999	Continued from page 8 lot of drinking and some people there are doing drugs. She said you will see people begging for $2 or $3 to get themselves something to eat and when they get the money, they will go to the convenience store and buy alcohol. On 09/09/25 at 2:25 PM, V1, Administrator stated she doesn't know why R2 was sent on a doctor's appointment without staff. She said her and two other staff members went to the doctor's office to check and see if he (R2) was there at the office. V2 said while they were at the doctor's office R2 returned to the facility. The facility's Leave of Absence policy, review date of 09/2024, documented "General: To document a resident has taken a leave of absence and verify their safe return." It further documented "3. The resident must let the nursing staff know when they are leaving and returning to the building. 4. When a resident is ready to leave, the resident or responsible party must let the nurse know where they are going and their expected return time. The resident or responsible party should call the facility if they are going to be late." It also documented "6. If the resident does not return by the anticipated time, the staff will try to contact the resident or their responsible party. 7. If the nurse cannot get a hold of the resident or responsible party, then the DON (Director of Nursing) and/or Administrator are notified and make a determination regarding alerting the police. 8. If the resident or responsible party does not return the resident to the facility as planned, the resident is considered AMA (Against Medical Advice) and the physician is notified. 9. If the resident does not return, the responsible party is notified within 24 hours. 10. The above will be documented in the progress notes." The facility's Appointments and Transportation policy, review date of 9/2024, documented Policy: "When a resident has an appointment outside of the facility, the staff will make the transportation arrangements, unless the responsible party choses to make the arrangements themselves. Purpose The purpose of this policy is to provide guidance for appointments and transportation in the facility." It further documented Procedure: "If the family will not be accompanying the resident, the staff nurse or designee will inform the DON (director of nursing) to determine if an escort is needed for the resident." (B)	S9999		