

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2025
NAME OF PROVIDER OR SUPPLIER  Bria of Cahokia		STREET ADDRESS, CITY, STATE, ZIP CODE  3354 Jerome Lane Cahokia, IL 62206	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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.

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

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 [DATE] directly after the appointment with non-emergency ambulance transportation provider or staff escort and instead returning on public transportation after going sightseeing. The Immediate Jeopardy began on 08/19/25 when Due to the facility's failure to properly assess and supervise a resident (R2) during an out of state physician's appointment. This failure resulted in R2 not returning to the facility on [DATE] and instead going sightseeing on public transportation. This comes following a history of R2 not returning to the facility as planned, after being signed out with V5, R2's friend and the facility not being able to locate R2, despite contacting the friend. R2 subsequently arrived back to the facility intoxicated after being on a leave of absence (LOA) on both 06/15/25 and 08/15/25. Findings Include: V1, Administrator, V20, Regional Operations, and V22, Registered Nurse Certified (RNC) were notified of the Immediate Jeopardy on 09/04/2025 at 10:46 AM. Abatement number one and two on 09/04/25 were not accepted. Abatement number three accepted on 09/04/25 at 2:44 PM. The Immediate Jeopardy was removed on 09/05/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. 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 [DATE], 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 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 [DATE] 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 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</p>		