STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44953 Based on interview and record review the facility failed to monitor the administration of medications as ordered by the physician for 5 of 5 residents (R1, R2, R9, R10, R11) reviewed for medications in a sample of 11. This resulted in residents receiving medications that were not prescribed for them or a delay in receiving prescribed medications. The findings include: 1. R1's Face Sheet undated documents R1's medical diagnosis as Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety, Encephalopathy, Unspecified, Cognitive Communication Deficit. R1's Physician Order Summary (POS) undated documents R1's medications as Remeron 15 mg (milligrams) at bedtime for weight loss related to depression; Levetiracetam 750 mg BID (twice of day) for seizures; Lisinopril 10 mg Daily for hypertension; Coreg 0.25 mg BID for hypertension; Lacosamide 100 mg BID for seizures and Clopidogrel 75 mg Daily related to cerebral infarction. R1's Minimum Data Set (MDS) dated [DATE] documents moderate cognitive impairment. R1's Incident Audit Report dated [DATE] documents resident (R9) revived (sic) medication from other resident (R1) and this resident took that medication. Resident (R1) stated that other resident said that other resident (R9) had this medication. [DATE] Meeting documented staff educated that when administering medications stay with the resident until all medications are given. RCA (root cause analysis): Medication left unattended and another resident give (sic) him the medication and he took it. On [DATE] at 10:05 AM, V7, LPN (Licensed Practical Nurse) stated I merely turned my back, I gave (R1) her medications and she gave them to (R9). 2. R2's Face Sheet undated documents R2's medical diagnosis as Metabolic Encephalopathy, Bipolar Disorder, Unspecified, Cognitive Communication Deficit, Sensorineural Hearing Loss, Bilateral (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's Physician Order Summary undated documents R2's pertinent medications as Venlafaxine ER 37.5 mg BID for depression, Hydroxyzine 25 mg every 4 hours as needed for anxiety, Divalproex Sodium Delayed Release 250 mg BID related to Bipolar Disorder, Seroquel 200 mg at bedtime related to bipolar disorder and Quetiapine Fumurate 25 mg BID related to encephalopathy. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact. On [DATE] at 2:01 PM, V3, son of R2 stated my mother (R2) does pretty well when she takes her medications and that is why I am concerned. I don't want her (R2) to go backwards. It worries me that if she is unaware of what's going on she could be given the wrong medication. According to my mother the nurse handed her medication that she did not recognize and then asked her if she was another resident (R1). On [DATE] at 9:30 AM, R2 stated another incident was when a night nurse gave her a cup of pills and they were not hers. (R2) stated the nurse actually put the cup of pills in her hand for her to take. R2 stated she did not take the pills because she did not recognize them. When she questioned the nurse, the nurse said aren't you (R1)? The nurse took the pills back and gave R2 the correct pills. R2 does not know who the nurse was, nor does she remember the date. On [DATE] at 10:48 AM, V11, Medical Director stated he was notified of the medication errors with other residents. (R2) reported the incident to him when he visited her in the facility. There was no harm to her (R2) since she did not actually take the medication. On [DATE] at 1:28 PM, V2, DON (Director of Nursing) stated she did receive a Grievance from (R2) regarding her medications last Wednesday. The Grievance is still in the investigative stage as she had only spoke to the day shift nurse (V7 LPN) who stated he thought (R2) had been given her medication. V2 stated she was unaware of the incident where (R2) is reporting that she was handed another resident's medication. V2 stated (R2's) concerns appear to be more around timing rather than actual medication. Staff were in-serviced last week on the facility's medication administration policy. 3. R9's Face Sheet undated documents R9's pertinent medical diagnosis as Cerebral Infarction, Unspecified; Parkinson's Disease without Dyskinesia, without Mention of Fluctuations; Anemia, Unspecified; Malignant Neoplasm of Cerebellum; Major Depressive Disorder, Recurrent, Moderate; Panic Disorder [Episodic Paroxysmal Anxiety]. R9's Physician Order Summary (POS) undated documents R9's medications as Amlodipine 2.5 mg Daily, Topiramate Tablet 50 MG at bedtime, Sertraline HCl Capsule 200 MG, Mirtazapine Tablet 15 MG, Meclizine HCl Oral Tablet 25 MG (Meclizine HCl), Tamsulosin HCl Capsule 0.4 MG. R9's Incident Audit Report dated [DATE] documents resident (R9) revived (sic) medication from other resident (R1) and this resident took that medication. Resident (R1) stated that other resident said that other resident (R9) had this medication. [DATE] Meeting documented staff educated that when administering medications stay with the resident until all medications are given. RCA: Medication left unattended and another resident give (sic) him the medication and he took it. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:05 AM, V7, LPN stated I merely turned my back, I gave (R1) her medications and she gave them to (R9). On [DATE] at 10:07 AM, R9 stated she told me it was my medicine; I took it. 4. R10's Face Sheet undated documents R10's pertinent medical diagnosis as Encephalopathy, Unspecified; Acute and Chronic Respiratory Failure with Hypoxia; Alcohol Abuse with Withdrawal, Uncomplicated; Anemia. R10's Physician Order Summary (POS) undated documents R10's medications as Amlodipine 2.5 mg Daily, Abilify 5 mg BID, Benztropine 1 mg BID, Carbidopa-Levopadopa ,d+[DATE] mg 1.5 tablet TID (three times a day), Topiramate Tablet 50 MG at bedtime, Sertraline HCl Capsule 200 MG, Mirtazapine Tablet 15 MG, Meclizine HCl Oral Tablet 25 MG (Meclizine HCl), Tamsulosin HCl Capsule 0.4 MG. R10's Minimum Data Set (MDS) dated [DATE] documents R10 has moderate cognitive impairment. R10's Incident report dated [DATE] documents his nurse mixed up resident bed number at 8 AM this morning with ,d+[DATE] instead of bed 2. resident received Baclofin, Nifedpine, and Zoloft. contacted ADON (Assistant Director of Nurses) and V10 Pharmacist. N.O (new order) to monitor b/p (blood pressure) and p (pulse) and hold carvedilol. resident has no c/o (complaint of) pain or discomfort last b/p and Pulse was , d+[DATE] and 84. On [DATE] at 10:05 AM, V7, LPN stated he was rushing and gave (R10) another resident's medication. (R10) was monitored for side effects of the medication. On [DATE] at 10:10 AM, R10 stated nothing happened. On [DATE] at 10:48 AM, V11, Medical Director stated (R10) has issues with hypertension and anxiety so the additional medication did not cause him (R10) any harm. 5. R11's Face Sheet undated documents R11's pertinent medical diagnosis as Multiple Sclerosis; Morbid (severe) Obesity Due to Excess Calories; Other Lack of Coordination; Iron Deficiency Anemia, Unspecified; Hypoglycemia, Unspecified; Major Depressive Disorder, Recurrent, Moderate R11's Physician Order Summary (POS) undated documents R11's medications as Loperamide HCl Oral Capsule 2 MG every 8 hours as needed, Cyclobenzaprine HCl Tablet 5 MG (0.5 tablet) TID, Cyclobenzaprine HCl Tablet 5 MG TID, DULoxetine HCl Capsule Delayed Release Particles 60 MG BID, TraZODone HCl Tablet 100 MG at bedtime; TiZANidine HCl Tablet 2 MG, Primidone Tablet 50 MG 2 tablets at bedtime. R11's Minimum Data Set (MDS) dated [DATE] documents R11 is cognitively intact. R11's Incident Report dated [DATE] documents R11 was administered Pregabalin 150 mg capsules of home supply medication that was sent with resident on admission. Physician ordered Pregabalin 100 mg capsules at bedtime. On 9a(am) dose the order was written as Pregabalin 100 mg 2 capsules and home supply was used of Pregabalin 150 mg (2 capsules) administering a total amount of 300 mg on 3 different administration occurrences. Resident is unaware of what Mg her dose was ordered as. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] Meeting to discuss Medication error on [DATE]. Nursing in-service began and to be completed 100% regarding Medication Administration policy, Medication error policy and home medication policy. All nurses are being given copies of all 3 policies. Disciplinary Action to be given. On [DATE] at 8:00 AM, R11 stated she is not having any problems getting her medications and she has no complaints. On [DATE] at 10:48 AM, V11, Medical Director stated (R11) medication mix-up actually started at the hospital. He is working with the hospital to use escripts to help eliminate some problems. The additional dosages were actually what (R11) was taking at home, and he was just trying to get control of her medication regimen. There was no harm caused to R11. R11's Electronic Monitoring Administration (eMARs) dated [DATE] documents the numeral 9 for dates , d+[DATE]; ,d+[DATE] and ,d+[DATE]. The numeral 9 denotes a nurses' note. R11's Nurse Progress Notes dated [DATE] documents the medication Lyrica (Pregabalin) was out, MD called for script, waiting on medications. On [DATE] at 11:30 AM, V10, Pharmacist stated their records are not showing a lapse in shipments for (R2) or (R11). In (R2's) case the facility is sent a 30 day supply of Depakote and Seroquel each time. A shipment was sent [DATE] and [DATE]. At doses 2x's /day she (R2) should not be running out of medication. In reference to R11, an order was shipped [DATE] and [DATE], again the facility was sent a 30 day supply for each medication. On [DATE] at 1:28 PM, V2, DON stated staff have re-ordered medication and it still has not come in. Staff will call to check on the medication and the pharmacy will then send the medication. V2 relies on the staff to follow-up on orders or re-orders and was unaware of a resident not receiving their medication. The facility policy on Medication Administration with a review date of ,d+[DATE] documents All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. (19) Identify resident using two resident identifiers. (21) Remain with the resident to ensure that the resident swallows the medication. (26) If medication is ordered, but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If unavailable, obtain from the contingency or convenience box.