

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
NAME OF PROVIDER OR SUPPLIER Bria of Belleville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44953</p> <p>Based on interview and record review staff failed to administer several significant medications for 1 of 1 resident (R4) during a scheduled medication pass.</p> <p>Findings include:</p> <p>R4's undated Face Sheet documents pertinent medical diagnosis as Metabolic Encephalopathy, Bipolar Disorder, Unspecified Protein Calorie Malnutrition, Cognitive Communication Deficit and Sensorineural hearing loss, bilaterally.</p> <p>R4's Physician Order Summary report undated documents orders for the following medications: Amlodipine 5 mg daily for Primary Essential Hypertension, Ouetiapine Furamate 25 mg twice a day related to Encephalopathy, Seroquel 200 mg at bedtime related to Bipolar Disorder and Venlafaxine Extended Release 37.5 mg twice a day for Depression.</p> <p>R4's Care Plan dated 4/16/24 documents Care Areas for psychotropic and Hypertension medications. The Interventions included Take the medication(s) as ordered.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] do not document any cognitive impairment.</p> <p>R4's Electronic Medication Administration Record (eMAR) dated 4/14/24 documents that R4 did not receive the 9:00 AM scheduled medications of 5 mg Amlodipine, 25 mg Quetiapine and 37.5 mg Venlafaxine Extended Release. The reason documented in Nurses' Progress notes.</p> <p>R4's Electronic Medication Administration Record (eMAR) dated 4/14/24 documents that R4 did not receive the 12:00 PM scheduled medication 25 mg Quetiapine. The reason documented in Nurses' Progress Notes.</p> <p>R4's Nurse Progress Notes dated 4/14/24 documents that R4's medication roll had run out.</p> <p>On 4/18/24 at 9:55 AM R4 stated I have had so many problems with my medications, I can't remember when I have gotten them as scheduled.</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/18/24 at 4:35 PM, V6, Licensed Practical Nurse (LPN) stated she was the nurse that did med pass yesterday and the 14th for the hall. She stated (R4) will request her medications then change her mind about taking them. Once the meds are discarded (R4) will ask for her medications. This will cause a shortage of meds for the week.</p> <p>On 4/18/24 at 4:40 PM, V10, LPN stated the pharmacy sends the medication in for the week in a roll. The meds are for Sunday to Sunday. The Night shift staff places the rolls of medication in the medication carts. There is no way to cross check the medications to ensure all the medications are sent in by the pharmacy.</p> <p>On 4/18/24 at 4:42 PM, V8, Infection Control Nurse stated it is unusual for a resident to run out of scheduled medications. There can be a problem with a psychotropic or a narcotic but not a routine medication. The nurse did report the problem to the DON (Director of Nursing), but it was not addressed.</p> <p>On 4/19/24 at 1:55 PM, V13, Nurse Practitioner stated, the facility did contact her and made her aware of the shortage of scheduled medications. (V13) had also discussed with the resident (R4) about ways to eliminate the wasting or discarding of medications. (V13) Believe this was a problem at a previous facility as well.</p> <p>On 4/19/24 at 2:40 PM, V14, Pharmacist stated (R4's) meds are filled on a 7 day basis and was last filled 4/12/24. The meds are on an automatic refill. If meds are discarded or dropped, they can be pulled from the med room. Amlodipine and Seroquel are significant medications.</p> <p>On 4/19/24 at 2:52 PM, V1, Administrator stated all nurses have access to the med room and have codes to enter to retrieve medications. (R4) was screened for a change in condition due to the missed medications and there was no change in BP (blood pressure) or behaviors.</p> <p>The facility Policy and Procedure on Medication Administration with a review date of 4/2024 documents if medication is ordered, but not present, check to see if it was misplaced and then call then pharmacy to obtain the medication. If available, obtain from the contingency or convenience box.</p>		