

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 05/30/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628</p> <p>Based on interview, observation and record review, the facility failed to assess, monitor, and treat pressure ulcers for 2 of 4 (R3, R6) residents reviewed for pressure ulcers in the sample of 9.</p> <p>Findings include:</p> <p>1. R3's Face sheet, undated, documents an original admitted [DATE]. Diagnosis includes osteoarthritis of knee, moderate protein-calorie malnutrition, unspecified anemia, essential primary hypertension, chronic embolism and thrombosis of other specified deep vein of left lower extremity, atelectasis, ileus, unspecified, other cholelithiasis without obstruction, other specified disorders of bone density and structure, unspecified multiple injuries, subsequent encounter.</p> <p>R3's Minimum Data Set, MDS, dated [DATE], section C, BIMS (Brief Interview of Mental Status) score is left blank, memory ok, independent in making decisions regarding tasks of daily life and shows no evidence of acute change in mental status from the resident's baseline. MDS dated [DATE], section GG, shows she needs assistance for eating and oral hygiene, needs maximal assistance for toileting hygiene, and upper body dressing and is dependent for bathing, lower body dressing, putting on and taking off footwear and personal hygiene. She also needs partial or substantial assist with rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand and chair /bed to chair transfer.</p> <p>R3's Care Plan with initiated date of 5/20/24, shows that R3 is at risk for skin complications related to moderate protein-calorie malnutrition. Interventions include encourage to turn and reposition every one to two hours and as needed, elevate head of bed no more than 30 degrees, ensure proper body alignment, maximal remobilization, monitor closely for sensory impairment, provide skin care after each incontinent episode, and skin assessment weekly. Care plan initiated 5/20/24, also shows risk for compromise in nutrition and hydration status, requires assist with daily care needs, risk for complications related to anemia, risk for falls related to functional deficits, risk for bleeding related to anticoagulation, potential for altered cardiac function, self-care deficit related to decreased ability, and range of motion loss.</p> <p>R3's progress note dated 5/20/24, document R3 was admitted with a primary diagnosis of multiple wounds to bilateral lower extremities, coccyx, hip and right thigh. Per patient, wounds developed as small scars and significantly increased over time. R3's interval history report that R3 is being followed by wound care. R3 is alert and orientated x3, without signs of recent infection.</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's hospital discharge referral records from (Local) Hospital dated 5/19/24 document an appointment for Wound center on 5/21/24 at 9:30 am. No other orders for wound treatment and management note.</p> <p>R3's Progress notes dated 5/20/24 1:07 pm state that V3 was admitted without wound care orders. V3, Wound Care Nurse, reports a call was placed to MD and orders were received with new orders to cleanse all wounds with wound cleanser then apply SSD (Silvadene) cream, cover with calcium alginate and cover with dry dressing daily. The right buttock wound order is cleansed with wound cleanser and then apply xeroform and cover with silicone bordered dressing daily.</p> <p>R3's Wound evaluation dated 5/20/24 documents R3 has a stage 2 pressure ulcer to the right gluteus measuring 3.1 cm x 1.1 cm x 0.1 cm (#6) and a stage 3 pressure ulcer on his sacrum measuring .91 cm x 1.9 cm x 0.2 cm. (#5). #6 was cleansed with wound cleanser, xeroform and covered by silicone bordered dressing. #5 cleansed with wound cleanser, calcium alginate, silver sulfadine and covered silicone bordered dressing. Other wounds include: #4 venous on right medial calf measuring 5.39 cm x 1.77cm x .2 cm, #3 venous ulcer of left medial calf measuring 5.4 cm x 3.81 cm by .2 cm, #2 venous front right later lower left measuring 5.06 cm x 4.29 cm x 0.2 cm, and #1 venous on front left lateral lower leg measuring 0 cm x 0 cm x 0 cm.</p> <p>On 5/28/24 at 1:30PM, V19, Licensed Practical Nurse (LPN), stated that he did not receive wound orders, so he called the hospital for additional orders and did not receive any further orders. V19 stated he did not call the on-call facility telehealth doctor for admitting orders for R3's wound. V19 further stated he did not assess R3's wounds or take off the dressing since he didn't have any orders and know what to put on. V19 stated R3's dressing was clean, dry and intact and was dated 5/19/24.</p> <p>On 5/28/24 at 1:07 pm, V3 LPN stated that there were no orders for R3's wound care on admission to facility.</p> <p>R3's May 2024 Treatment Administration Record documents that wound care was not performed on 5/21/24.</p> <p>On 5/20/24, at 4:27 pm V19, LPN, documented that R3 has a follow-up appointment with the wound clinic on 5/21/24 and he called and left a message that the resident will not be able to make appointment related to the appointment being scheduled too close to the admission day. He reported this to be rescheduled the next day.</p> <p>On 5/28/2024 at 2:15 pm, V3, LPN, stated that he did not perform wound care because R6 was due to go to the wound clinic that day, but no one informed him R3 did not go to the wound clinic.</p> <p>On 5/28/24 at 2:45 pm spoke with V2 DON. V2 reported that R3 was newly admitted and had only been in the facility a few days. When asked about the cancelled wound clinic appointment on 5/21, V2 reported that one day's notice is not enough time to arrange transportation and she was not aware of any issues with dressing changes on R3. V2 further stated she expected staff to assess wounds upon admission to the facility that included measurements and that residents receive wound dressing changings as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/29/24 at 9:25 am, spoke with V1 Administrator. V1 stated she expects assessment on wounds performed on the day of admission that include measurements and orders should be received for treatment. V1 then stated that if there are no wound orders, the facility's medical doctor should be contacted through telehealth that is available from 5:00 pm-8:00 am. The telehealth doctor will have orders and notes from the transferring hospital uploaded and the doctor can verify orders on admission and add any orders. V1 was unaware of any issues with the dressing change on R3.</p> <p>2. R6's face sheet, dated 5/30/24, documented that R6 was admitted on [DATE] with a diagnosis of toxic encephalopathy, severe protein calorie malnutrition, unspecified dementia, hypertension, intestinal malabsorption, other specified diseases of biliary tract, chronic viral hepatitis C, hypothyroidism, paranoid schizophrenia, genialized anxiety disorder, age related osteoporosis, primary osteoarthritis, left ankle and foot, and enterocolitis due to clostridium difficile.</p> <p>R6's MDS, dated [DATE], documented that their cognition was severely impaired with a BIMS of 00 and R6 requires moderate to max assistance for activities of daily living.</p> <p>R6's Orders Summary Report dated 5/20/24 documents a start date of 5/27/24 hydrogel gel apply to sacrum topically every day shift every mon wed fri for to promote wound healing, cleanse sacrum with outwound cleanser then apply hydrogel and collagen particles then cover with calcium alginate and dry dressing mon wed fri.</p> <p>R6's Interim Baseline Care Plan dated 5/20/24 documents skin condition: focus: actual alteration in skin integrity. Will show signs of healing through next review. Interventions: inspect skin daily with care, keep skin clean and dry, peri care after incontinent episode, monitor for s/s of infection, treatment as ordered.</p> <p>On 5/29/24 at 9:50am, V3, LPN, Wound nurse provided wound treatment to R6's pressure wounds. V6 rolled R6 to her right side and when he took off her brief, there was no dressing to R6's left buttock. A piece of calcium alginate was in the wound bed partially covering the wound bed and another piece of calcium alginate was in R6's brief but there was no dressing covering R6's wound. V3 stated at this time Where's my dressing? The calcium is there but no dressing. V3 stated of course I would expect R6's wound to have a dressing on it especially since she's had C-diff, at least put a dry dressing on it.</p> <p>On 5/29/24 at 2:20PM, V20, LPN stated she was the Infection Control Nurse and a Nurse Manager and that V2, DON was not in the facility today. V20 stated she expected staff to measure and assess each wound individually.</p> <p>On 5/30/24 at 11:00AM, V1, Administrator stated she used to be a PT and do wounds and expects staff to measure and assess wounds individually and that wounds should be covered.</p> <p>On 5/30/24 at 1:17PM, V24, Wound Nurse Practitioner stated she expects wounds to be covered with the treatment dressing that is ordered.</p> <p>The Facility's Wound Management dated 1/5/23 documents: Policy: It is the facility policy to treat wounds according to WOCN Clinical Practice Guideline Series, Agency for Healthcare Research and Quality (AHRQ), National Pressure Injury Advisory Panel (NPIAP), Wound, Ostomy, and continence Nursing Guidelines, and current standards of clinical practice.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Wound Cleansing and dressings dated 1/5/23 documents: Management Policy documents: B. Dressing application requires a provider order. Documentation: documentation of the dressing change is completed on the treatment administration record (TAR). Additional documentation is completed in the nurse's notes as indicated.</p> <p>Facility admission policy updated 4/2024 states that physician order sheet should reflect any standing orders specific to the resident as well as medications and treatments that are ordered throughout the stay.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on interview, observation, and record review, the facility failed to provide timely and complete incontinent care for 2 of 3 residents (R1, R7) reviewed for incontinence care in the sample of 9.</p> <p>The findings include:</p> <p>1. R1's Face Sheet, undated, documents R1 was admitted to the facility on [DATE] with diagnosis of Multiple Sclerosis, Morbid obesity, Dysarthria/Anarthria, Paraplegia, Hypothyroidism, Neuralgia/Neuritis, Ataxia, Major depressive disorder, Anxiety disorder, Anemia, Neuromuscular dysfunction of bladder, and Radiculopathy cervical region.</p> <p>R1's Care Plan, dated 4/21/24, documents R1 requires assist with daily care needs related to Multiple Sclerosis, paraplegia, neuroglia/neurotics. Utilizes 1/2 siderails x two to self-reposition and bed mobility. Interventions: Assist with Activities of Daily Living (ADLs), Encourage/ Assist with turning and repositioning every two hours and as needed, full body mechanical lift with two assist for transfers, monitor for changes with daily care abilities and provide more or less assist if needed, monitor skin integrity during routine care and report abnormal findings, notify Physician of any abnormal findings, provide rest periods during ADL care if needed, restorative program as appropriate, two person assist for transfers.</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact and is dependent on staff for toileting, dressing, transfers, and requires partial/moderate assistance from staff for all other ADLs. R1 is occasionally incontinent of both bowel and bladder.</p> <p>On 5/28/24 at 10:55 AM, R1 stated that she is incontinent of bowel and bladder, wears incontinence briefs, and is currently soiled. R1 stated that she has been wet all morning and no one has checked on her or cleaned her up. R1 stated the staff brought her a breakfast tray and dropped it off, but did not ask if she needed cleaned up, so she ate her breakfast while soiled. R1 stated the staff never check on her every two hours like they are supposed to.</p> <p>On 5/28/24 at 11:07 AM, V4, Certified Nursing Assistant (CNA), stated No, (R1) has not gotten up yet. She doesn't go to the restroom; she just goes on herself. She has not been cleaned up yet, I usually wait until she tells me she is wet. I did deliver her breakfast tray to her this morning and did not check her or clean her up at that time.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/24 at 11:12 AM, V4, CNA, came into R1's room to provide peri-care to R1. V4 did not do any hand hygiene prior to contact with R1. V4 ran the water in the sink to get it warm and placed several washcloths into the sink. V4 donned gloves, uncovered R1, obtained the wet washcloths from the sink, unfastened R1's incontinence brief which was saturated with large amounts of feces under her. V4 pushed the brief down between R1's legs and wiped once to right groin, and once to left groin. R1 was turned to her left side and V4 reached from behind and wiped between R1's legs from front to back. V4 had R1 raise her leg in the air so she can clean between her legs. V4 doffed her gloves, put more washcloths in the sink and put a name brand Body Wash onto the washcloths in the sink with running water. V4 left the room to get more washcloths and when entered again, V4 then donned gloves with no hand hygiene done. V4 gathered the soapy washcloths, and with R1 raising her leg again, V4 wiped between R1's legs again and then tucked the soiled bed pad and incontinence brief under R1. V4 got more wet washcloths and wiped R1's legs, buttocks, between her skin folds, and her anal area. V4 changed gloves, with no hand hygiene, wet more washcloths and again wiped R1's buttock and anal area again. Then using the same soiled gloves, put a clean incontinence brief down, rolled R1 over to her right-side showing feces on her left leg and hip area. V4 wiped the feces off, rolled R1 to her back and onto the clean brief and fastened the brief. Using the same soiled gloves as previously, V4 began dressing R1, putting her socks and pants on. V4 doffed her gloves and left the room with no hand hygiene done. There was no rinsing off the soap or drying of R1 during incontinent care.</p> <p>2. R7's Face Sheet, undated, documents R7 was admitted to the facility on [DATE] with diagnosis of wedge compression fracture to her first lumbar vertebra, Respiratory failure, Anemia, Atrial Fibrillation, Osteoarthritis, Osteoporosis, and Chronic peptic ulcer.</p> <p>R7's Care Plan, dated 4/28/24, documents R7 is at risk for skin complications related to decreased bed mobility and incontinence. Interventions: Address cause, if possible, assist and encourage resident to turn and reposition every one to two hours and as needed (PRN), notify Physician of abnormal findings, provide skin care after each incontinent episode, skin assessment weekly.</p> <p>R7's MDS, dated [DATE], documents R7 has a moderate cognitive impairment and requires substantial/maximal assistance from staff for ADLs. R7 is always incontinent of both bowel and bladder.</p> <p>On 5/28/24 at 9:45 AM, R7 stated the staff doesn't check on her and she has sat in urine for long times, especially at night. R7 stated that she lets them know she is incontinent when she can, and that sometimes the staff will come in and turn off the call light, and then don't come back to clean her up.</p> <p>On 5/28/24 at 9:50 AM, V18, R7's Daughter, stated My mom has been saturated in urine at times when I get here to visit. Sometimes if it is in the morning, her bed will be saturated from nights. I will tell the staff that she needs cleaned up and they usually come clean her up then.</p> <p>On 5/28/24 at 11:45 AM, R7 stated that she uses the call light when she needs assistance and sometimes it takes too long, often longer than 30-minutes. When asked when the last time it went that long during the night shift without being answered, she stated that it was just last night (5/27/24). R7 stated she put her call light on because she needed cleaned up. R7 stated that she was wet all night long. When asked how she felt about this, R7 stated, I feel yucky, not good. When asked the last time that she was cleaned up today (5/28/24), R7 stated, Early this morning, around 5:00 or 6:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/24 at 12:00, V16, CNA, entered R7's room and asked R7 if she needed to be cleaned up. R7 replied that she did need to be changed. V16 then left the room after saying he would clean her up and did not return.</p> <p>On 5/28/24 at 12:10 PM, V14, CNA, entered R7's room and began to transport R7 to the dining room for lunch, and just when reaching the dining room, V14 turned around and told R7 that she was going to take R7 back to her room to make sure she was dry.</p> <p>On 5/28/24 at 12:15 PM, V15, CNA, and V17, CNA Supervisor, came into R7's room and donned gloves. Incontinent care supplies were brought in and R7 was assisted back to her bed. R7's pants and incontinence brief were both wet, with the blue line wetness indicator present in her brief. R7's wheelchair pad was also noted to be wet. R7 was cleansed with peri-wash using appropriate incontinence care procedure with barrier cream applied once area dried. Folds under bilateral breast were washed and dried also with a mild pink area noted under left breast. R7 was then redressed with new shorts and assisted back to chair.</p> <p>On 5/30/24 at 10:10 AM, V13, CNA, stated I get here at 7:00 AM and start by filling up my supply/linen cart. I then go and check on all of my residents for any needs or incontinence. I check the residents to see if they are dry before breakfast and again before and after lunch.</p> <p>On 5/30/24 at 10:15 AM, V23 CNA, stated We should check the residents before taking them to the dining room or before delivering their meals. When doing peri-care, we should be changing gloves after each wipe and then do hand hygiene after care is done and before leaving the room.</p> <p>On 5/30/24 at 10:05 AM, V1, Administrator, stated I would expect the staff to check on each resident every two hours for incontinence and other needs, and to provide timely and complete incontinence care when needed.</p> <p>The facility's Incontinence Care Policy, dated 3/2023, documents Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown. 2. Perform hand hygiene and don gloves. 5. Clean peri area with appropriate cleanser and dry. Appropriate cleanser can mean soap and water, peri-wash, etc. Cleansing should always be from front to back. 11. Perform hand hygiene.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967</p> <p>Based on observation, interview, and record review, the facility failed to maintain steam table holding temperatures before and during meal service and to maintain food at the proper temperatures while preparing and serving meal trays to residents. This has the potential to affect all 121 residents residing at the facility.</p> <p>Findings include:</p> <p>1. R1's Face Sheet, undated, documents R1 was admitted to the facility on [DATE].</p> <p>R1's Minimum Data Set (MDS), dated [DATE], documents R1 is cognitively intact.</p> <p>R1's Physician Order, dated 1/27/24, documents Regular diet, Regular texture, Regular Liquids consistency.</p> <p>On 5/28/24 at 10:55 AM, R1 stated I eat in my room and the food is always cold.</p> <p>2. R7's Face Sheet, undated, documents R7 was admitted to the facility on [DATE].</p> <p>R7's MDS, dated [DATE], documents R7 has a moderate cognitive impairment.</p> <p>R7's Physician Order, dated 12/21/22, documents Regular diet, Regular texture, Regular Liquids consistency. Super cereal at breakfast.</p> <p>On 5/28/24 at 9:45 AM, R7 stated The food is always cold, all of it, no matter if I eat in my room or in the dining room. The cold food could be colder too.</p> <p>3. R8's Face Sheet, undated, documents R8 was admitted to the facility on [DATE].</p> <p>R8's MDS, dated [DATE], documents R8 is cognitively intact.</p> <p>R8's Physician Order, dated 5/3/24, documents Regular diet, Regular texture.</p> <p>On 5/28/24 at 11:50 AM, R8 stated I eat in my room and sometimes it's hot and sometimes it's cold.</p> <p>4. R9's Face Sheet, undated, documents R9 was admitted to the facility on [DATE].</p> <p>R9's MDS, dated [DATE], documents R9 is cognitively intact.</p> <p>R9's Physician Order, dated 5/14/24, documents Renal diet, Regular texture, Regular Liquids consistency.</p> <p>On 5/28/24 at 9:25 AM, R9 stated I usually eat in the dining room. The food is alright, but all the food is always cold.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/28/24 at 12:10 PM, V7, Dietary Manager, stated I already temped the food in the back, but will recheck it again if you want me to. The pureed food is the regular food just ground up (pureed). V7 did not know anything about calibrating the thermometer prior to temping.</p> <p>On 5/28/24 at 12:13 PM, V8, District Manager, stated We temp the food in the kitchen and again on the warmer before its served. V8 calibrated his and this surveyor thermometers using ice water and getting a temperature of 32.8 degrees Farenheight.</p> <p>On 5/28/24 at 12:15 PM, V8 checked the temperatures of the food, and the Chicken Parmesan patty was reading a temperature of 112 degrees Fahrenheit. V8 removed the tray of chicken from the warmer and took it back to the kitchen. V7 told V8 that the warmer section has not been working right for a while now. V8 brought a new tray of chicken out and placed in a different section of the warmer and re-temped the chicken which now read 162.6 degrees Fahrenheit.</p> <p>On 5/28/24 at 12:20 PM, V7 started plating food for the 100-hall and placing the plates on a food cart, which was an open metal cart with shelves.</p> <p>On 5/28/24 at 12:22 PM, both V7 and V8 stated that they always start with the 100-hall trays, then feed the dining room, then will deliver the 200-hall, 300-hall, 400-hall, and then the 500-hall.</p> <p>On 5/28/24 at 12:25 PM, while V7 was plating food, staff from the other side of the warmer was placing trays on top of the warmer which required an alternate, such as hamburgers. There was spilled noodles on top of the cart and when staff slid a tray on top, they pushed the noodles off the top and back into the tray of noodles on the warmer. V9 kept dishing out the noodles onto plates and was apparently unaware of this.</p> <p>On 5/28/24 at 12:34 PM, the 100-hall food cart was delivered to the 100-hall residents by the dietary staff and placed in the hallway for CNAs to deliver to residents. At 12:45 PM, the last lunch tray was delivered to the 100-hall residents. This took 11-minutes to pass out the food trays once delivered to the floor, and 25-minutes from first plate to last resident receiving their tray in their room.</p> <p>On 5/28/24 at 12:40 PM, the lunch plates started to be delivered to those residents in the dining room. Staff was in line in front of the warmer with each person taking one tray to a resident sitting at a table. No lid or cover was placed on the plates being delivered. At 1:18 PM, the last plate of food was delivered to a resident in the dining room. This took 38-minutes to pass out all meal trays to the dining room.</p> <p>On 5/28/24 at 12:55 PM, the mechanical soft food was placed on the warmer section that was not working. V8 re-checked the temperature which was now reading 138 degrees Fahrenheit. V8 stated If we don't hurry up, I will have to bring those trays back to the kitchen and bring up new ones.</p> <p>On 5/28/24 at 1:00 PM, V8 rechecked the temperature on the mechanical soft food again and was reading 135.8 and still dropping. V8 checked the holding water under the food trays in the warmer, and it was only 130 degrees Farenheight. V8 took all three mechanical soft trays back to the kitchen and brought out new trays which temped at 165 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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 05/30/2024
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.			
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/28/24 at 1:20 PM, a sample plate directly from the food warmer was given with the following temperatures noted: Noodles at 120 degrees Fahrenheit, Vegetables at 142 degrees Fahrenheit, and Chicken at 149.7 degrees Fahrenheit.</p> <p>On 5/28/24 at 1:26 PM, the Dietary staff started on the other hall trays. The 200-hall trays were seen being delivered to resident rooms with plastic wrap covering the plate, but no lid on the plates.</p> <p>On 5/28/24 at 1:30 PM, V8 stated We should have all the food carts lined up and ready to go, and we should be cleaning up by now.</p> <p>On 5/28/24 at 1:35 PM, the first plate of food was placed on the food cart for the 300-hall. The plates were covered with plastic wrap with no lids on top of the plates. At 1:45 PM, the food cart was being delivered to the 300-hall, when V8 stopped it and put lids on top of the plates, this was 10-minutes after the plates were placed on the cart.</p> <p>On 5/28/24 at 1:47 PM, the first plate of food was placed on the food cart for the 400-hall. The plates covered with plastic wrap, V8 again bringing out covers to put on plates just prior to sending to the floor. At 1:59 PM, the 400-hall cart was delivered to the residents on 400-hall. This took 12 minutes.</p> <p>On 5/28/24 at 2:05 PM, the first plate of food was placed on the 500-hall cart. At 2:14 PM, the food cart was delivered to the residents on 500-hall with plastic wrap and a cover.</p> <p>On 5/28/24 at 2:19 PM, another sample tray was the last tray after all 500-hall residents received their meals in their rooms. The Chicken temperature was at 132.4 degrees Fahrenheit, the Vegetables at 113.5 degrees Fahrenheit, the Noodles at 107.9 degrees Fahrenheit, and a bowl of Peaches was at 64.9 degrees Fahrenheit and warm to touch.</p> <p>On 5/29/24 at 1:56 PM, V14, Certified Nursing Assistant (CNA), stated The residents always complain about their food being cold, especially when eating in their room.</p> <p>The facility's Resident Council Meeting minutes, dated 3/28/24, documents Dietary: No consistency in food. Not enough. Menu wrong. Disrespectful.</p> <p>The facility's Resident Council Meeting minutes, dated 4/29/24, documents Dietary: Better food, want meat with breakfast, bread is sometimes stale, milk is bad.</p> <p>On 5/30/24 at 10:10 AM, V13, CNA, stated All the residents complain of cold food, and they don't like what's on the menus.</p> <p>On 5/30/24 at 10:15 AM, V23, CNA, stated When dietary delivers the food cart to our hall, we check the ticket on the tray and deliver it to the resident. All the residents complain about the food being cold.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bria of Belleville		STREET ADDRESS, CITY, STATE, ZIP CODE 150 North 27th Street Belleville, IL 62226	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/30/24 at 10:00 AM, V1, Administrator, stated I would expect the dietary staff to temp the foods to the proper temperatures and would expect the nursing staff to ensure the delivery of the food trays are done timely to prevent cooling of the food. The dietary department got a new plate warmer, and we were waiting on the metal plate bases and lids to arrive. Those supplies did arrive, and they should be using the warmer to help keep the food plates warm.</p> <p>The facility's Food Prep Policy, dated 9/2017, documents All foods are prepared in accordance with the FDA Food Code. 1. All staff will practice proper hand washing techniques and glove use. 2. Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. 4. The Dining Services Director/Cook will be responsible for food preparation techniques which minimize the amount of time the food items are exposed to temperatures greater than 41 degrees F (Fahrenheit) and/or less than 135 degrees F., or per State Regulation. 9. The Cook(s) will prepare all cooked items in a fashion that permits rapid heating to appropriate minimum internal temperatures. 10. Time/Temperature Control for Safety (TCS) hot food items will be cooked to a minimum internal temperature for 15 seconds as follows: Poultry and stuffed foods: 165 degrees F., Ground Meat: 155 degrees F., Fish, Pork, or other meats: 145 degrees F., and Unpasteurized eggs: 145 degrees F. 11. When hot pureed, ground, or diced food drop into the danger zone (below 135 degrees F.), the mechanically altered food must be reheated to 165 degrees F. for 15 seconds if holding for hot service. 13. All foods will be held at appropriate temperatures, greater than 135 degrees F. (or as State Regulation requires) for hot holding, and less than 41 degrees F. for cold food holding. 14. Temperature for TCS foods will be recorded at time of service and monitored periodically during meal service periods.</p> <p>The facility's Meal Distribution Policy, dated 9/2017, documents Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. 2. All food items will be transported promptly for appropriate temperature maintenance. 3. All foods that are transported to dining room areas that are not adjacent to the kitchen will be covered. 4. The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients. 6. Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining.</p> <p>The Facility Resident Census dated 5/28/24, documents that the facility has 121 residents residing in the facility.</p>		