

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  10/09/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on interviews and record reviews the Facility failed to notify the resident representative of a change of condition for 1 of 3 residents (R2) reviewed for change of condition in the sample of 6.</p> <p>Findings include:</p> <p>R2's Physician Order Sheet (POS) for October 2024 documents a diagnosis of amyotrophic lateral sclerosis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, morbid obesity, hypertension, depression, chronic pain and encounter for screening for COVID-19.</p> <p>R2's Facesheet documents R2 has four emergency contacts documented as the following family members, V9, V10, V11 who was also listed as emergency contact #2, and V12.</p> <p>R2's MDS dated [DATE] documents R2 is cognitively intact for decision making of activities of daily living. She uses a motorized wheelchair and is always incontinent of bowel and bladder.</p> <p>R2's Care Plan dated 11/21/2022 documents R2 was at risk for respiratory infection related to COVID-19. R2 was also documented for potential for difficulty in breathing related COPD, acute respiratory.</p> <p>R2's Progress Notes dated 9/25/2024 at 6:55 PM, Note Text: Resident sent to ED (emergency department) via EMS (emergency medical services) with c/o SOB (complaint of shortness of breath). O2 (oxygen saturations) sat's 79% during MD (Medical Doctor) consultation. Telehealth MD instructed this nurse to raise O2 concentration to 5L (liters). O2 sats improved to 91% but LOC remained affected. Telehealth MD instructed this nurse to send resident out due to change in condition. MD stated she would call report into (Hospital). No family member was documented as being contacted for her change of condition.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145668
		If continuation sheet Page 1 of 5

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/4/2024 at 1:22 PM, V11 stated his mom had SOB and became unresponsive and was sent out to the hospital but nobody from the facility notified any of them so they did not know she was in the hospital. When they came into the facility to visit her the staff were packing up his mother's belongings and it upset me. Why would they not call use to let us know my mom was in the hospital. She is still in the hospital. The last administrator was very hateful. I think they have a different administrator now. Still, I don't understand if my mom was sick enough to be sent out to the hospital why they could not call us and let us know.</p> <p>On 10/4/2024 at 1:39 PM, V1, Administrator stated she was not aware of the family of (R2), and they did not visit her very often. She was made aware that no family member was contacted for her change of condition before she was sent out to the hospital and if the family was notified, she would expect it to be charted in their nurse's notes.</p> <p>R2's Progress Notes dated 9/25/2024 at 11:35 AM, document Patient states she is not feeling good today and is very worried for her health situation. She reports her health concerns of being short of breath and unable to cough. Therapist notified nursing staff of patient concerns and nursing staff assessed patient.</p> <p>On 10/9/2024 at 2:00 PM, V22, Nurse Practitioner stated, If a resident has a history of ALS and they tell staff they are not feeling well, and they were having issues with breathing I would expect to be notified. If a resident was complaining of SOB, then I would expect to be notified. I would expect the O2 stats to be monitored at least every shift but without knowing the vitals it makes it difficult because if (R2's) vitals were not within normal limits then I would expect to be contacted immediately and sent out. I would expect all vitals to be charted and documented in the patient's chart. If (R2's) oxygen situations were below 90 and I felt she was in distress I would have sent out her sooner to the hospital.</p> <p>The Facility Change in Resident Condition Policy with a review date of September 2024 documents, It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician, and resident's responsible party of a change on condition. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and the family of the issues and any physician order. The communication with the resident and their responsible party as well as the physician will be documented in the resident; medical record or other appropriate documents.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on interviews and record reviews the Facility failed to assess, monitor, and perform vital signs for 1 of 3 residents (R2) reviewed for change of condition in the sample of 6. This failure resulted in R2's low oxygen saturation level, hospitalization , and being put on a ventilator, unable to return to the facility.</p> <p>Findings include:</p> <p>On 10/4/2024 at 1:22 PM, V1, Administrator stated, (R2) was recently sent to the hospital for a change of condition, and when she got to the hospital, she tested positive for COVID, and they admitted her for COVID and pneumonia. (R2) had to go on a ventilator. We do not take any residents with ventilators (vents) so she was going to be sent to another facility that takes vents and will not be returning to us.</p> <p>R2's Physician Order Sheet (POS) for October 2024 documents a diagnosis of amyotrophic lateral sclerosis, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, morbid obesity, hypertension, depression, chronic pain, and encounter for screening for COVID-19.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents R2 was cognitively intact for decision making of activities of daily living. She has impairments on both sides of her upper and lower extremities, uses a wheelchair and was dependent on most activities of daily living.</p> <p>R2's Care Plan: Respiratory: (R2) has potential for difficulty in breathing related COPD acute respiratory, date initiated 11/15/2023. Interventions: Assess respiratory status rate, depth, pattern, skin color. Monitor O2 (oxygen) Sats (saturation). Monitor every shift for shallow respiration, diaphoresis, dyspnea, monitor vital signs and lung sounds, observe for change in breathing pattern. All of the interventions listed were documented with the date initiated of 11/15/2023.</p> <p>R2's Progress Notes dated 9/25/2024 at 11:35 AM, document Patient states she is not feeling good today and is very worried for her health situation. She reports her health concerns of being short of breath and unable to cough. Therapist notified nursing staff of patient concerns and nursing staff assessed patient.</p> <p>R2' s Progress Notes dated 9/25/2024 at 6:56 PM, Resident sent to (ED) (emergency department) via EMS (Emergency Medical Services) with c/o (complaint of) SOB (shortness of breath). O2 sats 79% during MD (Medical Doctor) consultation. MD instructed this nurse to raise O2 concentration to 5 L (liters), O2 sats improved to 91% but LOC remained unaffected. MD (Medical Doctor) instructed this nurse to send resident out due to change of condition. MD stated she would call report into (Hospital).</p> <p>On 10/8/2024 at 9:44 PM, V13, Physical Therapist stated he was familiar with (R2), and he remembered she was a total assist, and her ALS (Amyotrophic Lateral Sclerosis) was progressing. The last time she had any therapy was on 8/30/2024 and she received speech therapy. (R2) did not have any therapy treatment, speech, or physical therapy on 9/25/2024. I am not sure what you are referring to. I have checked our records, and (R2) did not see any therapist on 9/25/2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/8/2024 at 10:07 AM, V6, Licensed Practical Nurse (LPN), stated, I am fairly new in the facility. I am the Wound Nurse. Earlier in the day some staff told me (R2) was having some discomfort and I took (R2's) O2 (oxygen) sats and she was at 96%. I called the Telehealth doctor and sent her out later in the day. I recorded her vital signs in the progress notes and on the (electronic medical charting) under vitals. When I first checked on (R2) she was not in respiratory distress. I remember at that time COVID was in the building and I know I did not test her for COVID but did send her out. I did not write the entry for (R2) on 9/25/2024 at 11:35 AM. Someone did come and get me; I believe it was someone from therapy and let me know she was having breathing issues.</p> <p>On 10/8/2024 at 10:34 AM, V1, Administrator stated, The only way anyone could write a note for a nurse's note is if they have a password. Once they make a note, they have to enter their password again in order for the note to go through. More than likely, (V6) just forgot she had written the note. I find it hard to believe anyone else has her code. She is fairly new and learning so much stuff.</p> <p>R2's Electronic vital signs do not document any vital signs were being performed on R2. Oxygen, temperature, and pulse were not documented on her chart, everything was blank after 9/19/2024. No vital signs were documented for 9/25/2024 except for the oxygen levels on 9/25/2024 at 6:56 PM, no other O2 levels were documented when R2 stated she was having shortness of breath on 9/25/2024 at 11:35 AM.</p> <p>On 10/8/2024 at 1:57 PM, V18, Certified Nursing Assistant (CNA) stated, I remember (R2), her breathing was very rapid, and you could tell she was off. I immediately went and got the nurse, this was right before lunch, and let her know she was having issues with her breathing and said she did not feel good. If I charted anything, like her vitals it would be in PCC. I can't remember if I charted anything, but I did go and get (V6) and let her know what was going on. Then later that night (R2) was sent out to the hospital. The nurse was (V6, LPN). We can chart and/or the nurse can chart vitals. If we chart anything it will be in the (electronic charting system)</p> <p>On 10/8/2024 at 1:50 PM, V2, Corporate Nurse/Director of Nursing stated, I would expect all change of conditions to be charted in the charts and all vitals to either be in the Progress Notes and or (electronic charting system).</p> <p>On 10/8/2024 at 2:03 PM, V19, CNA stated, I remember the day (R2) went out to the hospital because she was not looking good. She could talk and she said she was having issues breathing. This was right before lunch. I remember telling the nurse and then later she was sent out to the hospital. The nurse was (V6), I believe.</p> <p>R2's Progress Notes dated 9/26/2024 4:18 AM, documents, Note Text: Resident was sent to (Hospital) for low O2 sats. I called (hospital) and they stated that (R2) is intubated at this time.</p> <p>On 10/9/2024 at 2:00 PM, V22, Nurse Practitioner stated, If a resident has a history of ALS and they tell staff they are not feeling well, and they were having issues with breathing I would expect to be notified. If a resident was complaining of SOB, then I would expect to be notified. I would expect the O2 stats to be monitored at least every shift but without knowing the vitals it makes it difficult because if (R2's) vitals were not within normal limits then I would expect to be contacted immediately and sent out. I would expect all vitals to be charted and documented in the patient's chart. If (R2's) oxygen situations were below 90 and I felt she was in distress I would have sent out her sooner to the hospital.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p>R2's Hospital Notes dated 9/25/2024 documents, 7:00 PM, (R2) is a 58 y.o. (year old) female presenting to the ED (emergency department) c/o (complaint of) respiratory distress, EMS (Emergency Medical Services) reports they found the patient in significant respiratory distress. They immediate placed her on a non-rebreather with minor improvement. Impression: 9/26/2024 Patient presented to ED via EMS with respiratory distress, Patient intubated in ED. Plan includes respiratory, infection disease and medical management, isolation, ventilator, IV antibiotics, remdesivir and steroids.</p> <p>The Facility Change in Resident Condition Policy with a review date of September 2024 documents, It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician, and resident's responsible party of a change on condition. Once the physician has been notified and a plan developed, the nursing or social service staff will alert the resident and the family of the issues and any physician order. The communication with the resident and their responsible party as well as the physician will be documented in the resident medical record, or other appropriate documents.</p>		