STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145785	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Mascoutah	901 North Tenth Street Mascoutah, IL 62258

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to verify and implement a consultant physician's instructions, failed to follow hospital discharge orders for normal saline indwelling urinary catheter flushes, and failed to document a resident's response to antibiotics for 1 of 3 residents (R2) reviewed for quality of care in the sample of 11.Findings include:R2's admission Record document, print date of 8/18/25, documented R2 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses including Wernicke's encephalopathy, type 2 diabetes mellitus, chronic gout, insomnia, alcohol abuse, major depressive disorder, polyneuropathy, hypertension, and obstructive and reflux uropathy.R2's MDS (Minimum Data Set), dated 7/14/25, documented R2 was severely cognitively impaired, dependent on staff for toileting and hygiene needs, and had an indwelling urinary catheter.R2's care plan, initiation date of 6/30/25, documented R2 required use of an indwelling catheter related to obstructive uropathy and was at risk of infection. Care plan interventions include monitor for s/s (signs/symptoms) of UTI (urinary tract infection), notify MD (Medical Doctor) of abnormal findings, staff to monitor patency of catheter, and record output as directed. R2's care plan did not address indwelling catheter care although R2's admission orders, dated 6/30/25, documented indwelling catheter care every shift as needed.R2's progress notes, dated 7/3/25, documented at 4 PM while assisting CNA (Certified Nurse Assistant) noted urine in drainage bag to have the appearance of thin beige liquid. (Family of R2) states she would like this to be expedited. Call placed to NP (Nurse Practitioner) at 4:40 PM, received order to send out to ER (Emergency Room) if family desired. At 4:50 PM, family stated they would like him sent to ER.R2's hospital Discharge summary, dated [DATE], documented R2 was hospitalized with severe sepsis secondary to CAUTI (catheter associated urinary tract infection). Suspect (indwelling urinary catheter) was dislodged or clogged as patient had immediate large volume output with new (indwelling urinary catheter) placement.R2's hospital discharge orders, dated 7/5/25, documented an order to flush R2's indwelling urinary catheter with 30 ML NS (normal saline) BID (two times per day).R2's facility progress note, dated 7/5/25 at 5:55 PM, documented resident returned to the facility by way of (local) EMS (emergency medical service) in company of (R2's Family). Resident is alert and oriented x 1-2, (indwelling urinary) catheter in place draining yellow urine with small amount of sediment noted in the tubing. New orders for amoxicillin 500 mg PO (by mouth) every 12 hours for 7 days and Keflex 500 mg PO 3 times daily for 10 days. Instructions to flush (indwelling urinary) catheter with 30 ml of saline every 12 hours. R2's MAR (Medication Administration Record), dated 7/2025, documented an order, dated 7/5/25, to flush R2's indwelling urinary catheter with 30 CC H20 Q 12 hours (water every 12 hours). This MAR documented R2's indwelling urinary catheter was flushed with 30 CC H20 Q 12 hours twice a day from 7/7/25 through 7/31/25. On 8/18/25 at 1:55 PM V3 LPN/CPC (Licensed Practical Nurse/Care Plan Coordinator) stated she completed the admission for R2 on 7/5/25, the indwelling catheter flush order didn't specify what it should be flushed with. V4 stated she put the order in as water. Surveyor asked V4 what kind of water was used for the flushes and V4 replied tap water. Surveyor requested that order.On 8/18/25 at 2:04 PM V3 came to surveyor and stated I know where that water order came from, it was from R2's urologist on 8/4/25. V4 presented the order, the order documents catheter flushing every 8 hours. The order does not specify what to flush with. R2's progress note, dated 8/4/25 at 9:27 AM, documented left facility for appointment with urologist. Accompanied by (R2's Family) and CNA (Certified Nurse Assistant).R2's after visit summary from R2's urologist, dated 8/4/25 at 10 AM, documented instructions for topical antibiotics around the tip of R2's penis and indwelling urinary catheter flushing every 8 hours.R2's progress note, dated 8/4/25 at 1:18 PM, documented returned to facility at this time. No changes in orders. R2's progress notes do not document the instructions to increase R2's indwelling urinary catheter flush to every 8 hours, no documentation of any facility nursing staff calling R2's physicians for clarification of what to flush R2's catheter with, nor does it document a topical antibiotic was ordered for R2's penis pain and infection.On 8/18/25 at 8:06 AM V11, (R2's Family), stated she did inform R2's nurse of R2's new orders from his urologist for topical antibiotics and to increase R2's indwelling urinary catheter to every 8 hours from every 12 hours. V11 stated she provided the facility nurse with a copy of the orders. V11 stated she had a care plan meeting with the facility staff on 8/5/25 to discuss a very long list of issues and she brought up the catheter flush upgrade to every 8 hours as well as the topical antibiotic and R2's reporting of pain at his penis. V11 stated when she visited R2 on 8/8/25 and R2 once again told her the tip of his penis hurt. V11 stated she approached the nurse's station to check

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to properly clean an indwelling urinary catheter, failed to complete and document indwelling catheter care as ordered, failed to verify an indwelling urinary catheter flush order, failed to monitor intake and output as ordered, and failed to ensure a resident's indwelling was properly positioned and covered for 3 of 3 residents (R1, R2, R5) reviewed for indwelling urinary catheters in the sample of 11. These failures caused R2 to experience increased pain and sepsis secondary to developing a catheter associated urinary tract infection. Findings Include:1. R2's admission Record document, print date of 8/18/25, documented R2 was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses including Wernicke's encephalopathy, type 2 diabetes mellitus, chronic gout, insomnia, alcohol abuse, major depressive disorder, polyneuropathy, hypertension, and obstructive and reflux uropathy.R2's MDS, dated [DATE], documented R2 was severely cognitively impaired, dependent on staff for toileting and hygiene needs, and had an indwelling urinary catheter.R2's care plan, initiation date of 6/30/25, documented R2 required use of an indwelling catheter related to obstructive uropathy and was at risk of infection. Care plan interventions include monitor for s/s (signs/symptoms) of UTI (urinary tract infection), notify MD (Medical Doctor) of abnormal findings, staff to monitor patency of catheter, and record output as directed. R2's care plan did not address indwelling catheter care although R2's admission orders, dated 6/30/25, documented indwelling catheter care every shift as needed.R2's TAR (Treatment Administration Record), dated 7/2025, documented an order for indwelling catheter care every shift as needed. This TAR did not document R2's catheter care was completed at all on 7/2/25 nor was it completed on every shift as ordered on 7/11/25, 7/21/25, nor 7/23/25. This TAR documented monitor urine for infection q (every) shift. This TAR did not document this was completed on 7/2/25. This TAR also documented monitor (indwelling urinary catheter) placement q shift. This TAR does not document it was completed every shift on 7/2/25, 7/6/25, 7/10/25, 7/12/25, 7/21/25, nor on 7/23/25.R2's TAR, dated 8/2025, does not document R2's catheter care was completed every shift as ordered on 8/8/25.R2's progress note authored by V12 Nurse Practitioner, dated 7/1/25, documented obstructive and reflux uropathy, unspecified, continue (indwelling catheter) care and management. Monitor I&O (intake and output).R2's catheter output record, dated 7/1/25, did not document any output on 7/1/25, nor did it document R2's urinary output was completed every shift on 7/6/25, 7/8/25, 7/10/25, 7/12/25, 7/13/25, 7/14/25, nor on 7/15/25.R2's output record, print date of 8/20/25, does not document R2's urine output was monitored every shift as ordered on 7/22/25, 7/30/25, 7/31/25, 8/1/25, 8/3/25, 8/5/25, 8/6/25, 8/7/25, nor 8/10/25.R2's fluid intake records for July and August of 2025 are not documented every shift as ordered on 7/1/25, 7/2/25, 7/6/25, 7/8/25, 7/10/25, 7/12/25, 7/13/25, 7/14/25, 7/15/25, 7/18/25, 7/21/25, 7/30/25, 7/31/25, 8/1/25, 8/4/25, 8/5/25, 8/6/25, 8/8/25, and 8/10/25.R2's progress notes, dated 7/3/25, documented at 4 PM while assisting CNA (Certified Nurse Assistant) noted urine in drainage bag to have the appearance of thin beige liquid. (R2's Facily) states she would like this to be expedited. Call placed to NP (Nurse Practitioner) at 4:40 PM, received order to send out to ER (Emergency Room) if family desired. At 4:50 PM, family stated they would like him sent to ER.R2's hospital Discharge summary, dated [DATE], documented R2 was hospitalized with severe sepsis secondary to CAUTI (catheter associated urinary tract infection). Suspect (indwelling urinary catheter) was dislodged or clogged as patient had immediate large volume output with new (indwelling urinary catheter) placement.R2's hospital discharge orders, dated 7/5/25, documented an order to flush R2's indwelling urinary catheter with 30 ML NS (normal saline) BID (two times per day).R2's facility progress note, dated 7/5/25 at 5:55 PM, documented resident returned to the facility by way of (local) EMS (emergency medical service) in company of (R2's Family). Resident is alert and oriented x 1-2, (indwelling urinary) catheter in place draining yellow urine with small amount of sediment noted in the tubing. New orders for amoxicillin 500 mg PO (by mouth) every 12 hours for 7 days and Keflex 500 mg PO 3 times daily for 10 days. Instructions to flush (indwelling urinary) catheter with 30 ml of saline every 12 hours.R2's MAR (Medication Administration Record), dated 7/2025, documented an order, dated 7/5/25, to flush R2's indwelling urinary catheter with 30 CC H20 (water) Q 12 hours. This MAR documented R2's indwelling urinary catheter was flushed with 30 CC H20 Q 12 hours twice a day from 7/7/25 through 7/31/25.On 8/18/25 at 1:55 PM V3 LPN/CPC (Licensed Practical Nurse/Care Plan Coordinator) stated she completed the admission for R2 on 7/5/25, the indwelling catheter flush order didn't specify what it should be flush with. V4 stated she put the order in as water. Surveyor asked V4 what kind of

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow the facilities policy and don proper PPE (personal protective equipment) while providing care for 2 of 3 (R1, R5) residents reviewed for indwelling urinary catheter in the sample of 11. 1.R1's admission Record, print date of 8/18/25, documented R1 has diagnoses including rheumatoid arthritis, malnutrition, chronic fatigue, heart failure, altered mental status, neuromuscular dysfunction of bladder, cognitive communication deficit, hypertension, and acquired absence of right shoulder. R1's MDS (Minimum Data Set), dated 7/11/25, documented R1 is moderately cognitively impaired.R1's care plan, undated, documented R1 has an (indwelling urinary catheter) related to neurogenic bladder and is at risk of infection. R1's care plan also documented R1 requires enhanced barrier precautions with interventions including staff to wear gown and gloves when performing ADL'S (activities of daily living). On 8/18/25 at 8:38 AM R1 was observed in bed with her breakfast in front of her. R1's indwelling urinary catheter bag was uncovered and lying directly on the floor under the bed. V3, Care Plan Coordinator/LPN (Licensed Practical Nurse) walked in and stated to R1 where is your catheter bag? V3 then picked the catheter bag up off the floor, placed the bag in the bag cover, and attached it to R1's bed. V3 did not don gloves nor a gown prior to touching R1's catheter bag, catheter tubing, and R1's bed. R1's door was clearly marked with a sign noting enhanced barrier precautions and PPE (personal protective equipment) was readily available on R1's door caddy. 2.R5's admission Record document, print date of 8/18/25, documented R5 has diagnoses including multiple myeloma, ataxia following nontraumatic intracranial hemorrhage, polyneuropathy, glaucoma, hypertension, benign prostatic hyperplasia, and obstructive and reflux uropathy. R5's MDS, dated [DATE], documented R5 is moderately cognitively impaired although at time of interviews R5 was alert and oriented. R5's care plan, undated, documented R5 is at risk for complications related to receiving chemotherapy, R5 requires use of an indwelling catheter related to obstructive uropathy and is at risk of infection, and R5 requires enhanced barrier precautions (EBP) related to indwelling medical device. R5's care plan interventions include staff to wear gown and gloves when performing ADL's (activities of daily living) including when providing hygiene care. R5's physician orders, print date of 8/18/25, documented orders for enhanced barrier precautions for indwelling medical device urinary catheter.On 8/18/25 at 11:02 AM V6 CNA (Certified Nurse Assistant) and V9 CNA were observed as they provided indwelling urinary catheter care for R5. V6 and V9 had the clean supplies set up on a bedside table covered with a clean towel although the clean gloves were off to the side of the towel and directly on the bedside table. R5's door to his room is clearly marked with enhanced precautions signs and PPE (personal protective equipment) including gowns was readily available on the isolation door supply caddy. Neither V6 nor V9 donned gowns at any time during this observation. On 8/20/25 at 3:14 PM V1 Administrator stated she expects all facility staff to wear a gown and gloves when caring for residents on enhanced barrier precautions.The facility's Enhanced Barrier Precautions (EBP) policy, dated 10/6/22, documented Policy: Our facility employs the use of Enhanced Barrier Precautions to reduce transmission of MDROs (multi-drug resistant organisms) to staff hands and clothing that employs targeted gown and glove use during high-contact resident care activities. EBP are indicated for residents with any of the following: open wounds regardless of MRDO status, an indwelling medical device regardless of MDRO status, or colonization with a targeted MDRO. Process: Staff utilize gown and gloves for high-contact resident care activities when residents require EBPL high contact activities may include: dressing, bathing, transferring, providing hygiene changing linens, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tub, tracheostomy/ventilator, and would care.