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	08/12/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interview, observation, and record review the facility failed to promote respect and dignity in an environment that promotes maintenance by not providing timely removal of urine and feces from a resident's bedside commode for 1 of 1 resident (R11) reviewed for dignity in a sample of 41. Findings include: R11 was admitted to the facility on [DATE] with diagnosis of, in part, anxiety and major depressive disorders, fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing and lack of coordination. R11's Minimum Data Set (MDS) dated [DATE] documents R11 as being moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 9. During this investigation, R11 was alert and oriented to person, place and time. R11's MDS further documents R11 requires partial/moderate assistance for: toilet transfer: The ability to get on and off a toilet or commode and toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. R11's MDS documents further that R11 uses a wheelchair and requires partial/moderate assistance to walk. R11's current care plan dated 7/19/2024 documents R11 requires assistance with daily care needs related to weakness, fracture of spine with interventions to assist R11 with activities of daily living (ADLs) and monitor for changes with daily care abilities, provide more or less assist if needed, and rounding at a minimum of every 2 hours and prompt or assist for change in position, toileting, offer fluids, and ensure resident is warm and dry. On 8/5/24 at 10:15 AM, R11 stated she must use a bedside commode which also attracts the flies if staff don't clean it out timely. Stool is seen smeared on R16's floor by her commode. R11 stated she notified staff 4 hours prior that her commode needed to be emptied and is still waiting. R11 stated she hopes and prays the commode will be cleaned out by the time she has to use it again. R11 stated she doesn't ask for much but asking for her commode to be changed doesn't seem like a lot. On 8/5/24 at 11:00 AM, R11 was on her commode and stated it had not been cleaned yet, but she had no other choice but to use it. R11 pressed her call light and waited for 5 minutes for staff to respond but stated did not want to continue sitting over her dirty commode with all the flies. R11's commode was full of stool, urine, and tissues. Stool is still smeared on R16's floor. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/6/24 at 10:30 AM, R11's floor is still dirty with the same stool smears on the floor from yesterday. On 8/6/24 at 2:29 PM, bedside commode still not cleaned out. On 8/8/24 at 9:00 AM, R11 was eating her breakfast on the side of her bed with flies and a full commode filled with stool, urine, and tissues. On 8/8/24 at 9:15 AM, V2, Director of Nursing (DON), observed R11's full commode and flies in her room. V2 stated she would expect the commode to be changed out after R11 uses it, and she will clean it right now. The facility's Resident Rights Policy dated 10/2023, documents, The facility will provide a safe, clean, comfortable, and homelike environment .The residents' environment will be maintained in a homelike manner.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on interview and record review the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) of Non-coverage for 1 of 3 (R6) reviewed for Beneficiary Notice in the sample of 41. Findings include: R6's Admission Record documented an admitted to the facility of 12/05/2023. Diagnoses listed on this same document include, but are not limited to: Osteomyelitis of Vertebra, Morbid (Severe) Obesity due to excess calories, Weakness, Difficulty Walking, not elsewhere classified . The document titled Beneficiary Notice - Residents discharged Within the Last Six Months noted R6 remained in the facility but listed a service discharge date of [DATE]. Review of R6's Electronic Health Record (EHR) does not note a SNF ABN form associated with the 3/3/24 service discharge date . R6 was interviewed on 8/12/24 at 9:10 am and asked if she received a SNF ABN regarding her 3/3/24 discharge from services and she stated that she does not remember. On 8/6/24 at 9:33 AM, V1 (Administrator) stated that the facility did not issue a SNF ABN to R6 with her 3/3/24 discharge date from services. V1confirmed the lack of a SNF ABN form in R6's EHR as well as the facility's NOMNC (Notice of Medicare Non-Coverage) folder. V1 acknowledged the error in the facilities failure to provide the notice. V1 stated that the facility does not have a current policy regarding the issuing of SNF ABN forms, and just follow current regulatory guidelines.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on interview and record review, the facility failed to notify the resident in writing of the involuntary discharge and opportunity for appeal for 1 of 1 residents (R51) and no written notification was sent to the family for 1 of 1 residents (R9) reviewed for discharge in a sample of 41. Findings include: 1. R51's undated admission record documents an admitted [DATE]. R51's Progress note, dated 5/27/2024 at 6:39 pm, documented Resident arrived at facility via EMS (emergency medical services). A&O (alert and oriented) x4 and able to let needs be known to staff. R51 is documented to be continent of bowel and bladder. No c/o (complaints of) pain or discomfort. Respiration even and non-labored. BS (bowel sounds) active. Resident oriented to room and use of call light. R51's Progress note dated 5/28/24 at 8:35 am documented Patient was in 08/06/24 01:54 PM pain and rated it a 14 on a scale of 0-10. When speaking with the patient and her husband, they requested to be sent back to the hospital. Patient left facility via EMS with husband to local hospital, ER (emergency room) notified. Patient was admitted to med Surg (medical/surgical) on 500 unit of hospital with UTI (urinary tract infection) and pain control management, according to RN (registered nurse) at local hospital. On 08/06/24 at 1:30 PM, Review of R51's records found no documentation that the husband received in writing the reason for discharge to the hospital along with a bed hold notice. 08/06/24 1:55 PM Spoke with V1 (Administrator) who would have expected R51's family to have been provided with a bed hold notice and to notify R51's husband in writing of the reason for discharge to the hospital. 50908 2. On 8/05/24 at 9:35 AM, R9 was sent to hospital after fall. V17, Power of Attorney (POA), stated she was notified through her phone but did not receive any paperwork on transfer. On 8/06/24 at 2:12 PM, the facility's Bed Hold Policy with last review date of 9/2023 documents, upon admission and before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide written information to the resident or the resident's representative On 8/06/24 at 2:25 PM, V1 (Administrator) stated there is no documentation that written information was sent out to R9's representative after being hospitalized [DATE]. V1 stated there should have been written information sent out at the same time the bed hold notification was completed. On 8/12/24 at 09:59 AM, review of the facility's Discharge Policy dated 9/2023, does not document the need to provide written notification to resident's representatives upon transfers.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50628 Based on interview and record review, the facility failed to notify the resident in writing of the voluntary discharge and bed hold notice for 1 of 1 residents (R51) reviewed for discharge in a sample of 41 On 08/06/24 02:28 PM, Admission profile undated documents admission on 5/27/24. R51's Progress note, dated 5/27/2024 at 6:39 pm, documented Resident arrived at facility via EMS (Emergency Medical Services). A&O (alert and oriented) x4 and able to let needs be known to staff. Resident cont (continent) of b&b (bowel and bladder). No c/o (complaints of) pain or discomfort. Respiration even and non-labored. BS (bowel sounds) active. Resident oriented to room and use of call light. R51's Progress note dated 5/28/24 at 8:35 am documented Patient was in 08/06/24 01:54 PM pain and rated it a 14 on a scale of 0-10. When speaking with the patient and her husband, they requested to be sent back to the hospital. Patient left facility via EMS with husband to local hospital, ER (emergency room) notified. Patient was admitted to med Surg (medical/surgical) on 500 unit of hospital with UTI (urinary tract infection) and pain control management, according to RN (registered nurse at local hospital. On 08/06/24 01:30 at PM, Review of R51s records found no documentation that the husband received in writing the reason for discharge to the hospital along with a bed hold notice. On 08/06/24 at 01:55 PM, Spoke with V1, Administrator who would have expected R51's family to have been provided with a bed hold notice and to notify R51's husband in writing of the reason for discharge to the hospital.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on interview and record review the facility failed to follow nurse practitioner recommendations in a timely manner for 1 of 41 (R35) residents reviewed for quality of care in a sample size of 41. Findings include: R35's Face Sheet, print date of 08/12/24, documented R35 has diagnoses of but not limited to unspecified open wound, left lower leg, Type II Diabetes Mellitus, paraplegia, complete, and polyneuropathy. R35's Minimum Data Set (MDS), dated [DATE], documented R35 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and he is dependent on staff for bed mobility, transfers, and most of his dressing. R35's Care plan, admitted [DATE], documented SKIN: At risk for skin complications related to (r/t) immobility. R35's Physician's Orders, dated 07/12/24, documented referral to vascular surgeon, peripheral artery disease, delayed wound healing. R35's Physician's Orders, dated 07/27/24 documented an order was placed for R35 to get a magnetic resonance imaging (MRI) of the left knee related to nonhealing wound to left lateral knee for further evaluation and treatment. Review of R35's electronic medical record (EMR) was completed and has no documentation R35 was referred to any vascular surgeon regarding delayed wound healing or an appointment for an MRI was scheduled. On 08/08/24 at 10:25 AM, R35 stated the staff don't come in and turn/reposition or even offer to turn him every two hours. R35 was asked if he ever refused to be turned/repositioned and he stated no he hasn't. R35 stated he hasn't had an MRI done or had a consult with the vascular surgeon. He said the Nurse Practitioner (NP) had recommended those be done but as far as he knew nothing had been scheduled yet. R35 stated he has had an x-ray done and a doppler done but that is all he's had done. R35 stated this has been going on quite a while with his legs. On 08/08/24 at 11:50 AM, V26, Receptionist was asked if she is responsible for setting up appointment for the residents. She said yes, she is, and she also arranges transportation for them. V26 was questioned if R35 has any appointments coming up. V26 stated she called the hospital on 08/05/24 to set up R35 an appointment for an MRI and she is waiting for the department who does the MRIs to call her back and schedule the appointment. V26 said she will usually wait three days for them to call her back and if she hasn't heard anything in those three days, she will call them back. She said it's been three days so she will call them back tomorrow. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 12:00 PM, Follow up interview was conducted with V26, Receptionist at this time. V26 was asked who is responsible for setting up consults here at the facility. She said she was the one who does those. V26 stated the NP will put in the order, she will take the order and find a doctor who takes the residents insurance, and then she will fax over a referral and then they will go from there. When V26 was asked of R35 had any consults V26 stated not that she knows of. She said the only appointments she knows of are the two she told me about. The MRI and the Esophagogastroduoden endoscopy (EGD). On 08/12/24 at 10:17 AM, V1, Administrator stated she would expect the nurse to enter the doctor's or NP's order, get the consent, and to notify the pharmacy if needed. She also stated she would expect the nurse to let the transportation/scheduler know that the doctor or NP has ordered a consult with another doctor so she could get the appointment scheduled. On 08/12/24 at 10:40 AM, This surveyor requested the facility's policy regarding following physician's orders when scheduling a consult. V1 stated they do not have a policy for that they do have one for physician's orders regarding medications but that is the only one they have. The Resident Census and Conditions of Residents, CMS 671, dated 8/5/24, documents that the facility has 50 residents living in the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record, review, the facility failed to use appropriate safety procedures to assure resident safety during transfer for 1 of 3 (R5) reviewed for resident safety in the sample of 41. The findings include: R5's Admission Record, undated, documents R5 was admitted to the facility on [DATE] with diagnosis of Dementia, Cerebral Infarction, Traumatic Brain Injury (TBI), Dysphagia, Falls, Major depressive disorder, COVID, Hypertension, Osteoarthritis, and Convulsions. R5's Care Plan, dated 6/25/24, documents R5 has a potential for Activities of Daily Living (ADL) self-care performance deficit related to Diagnosis TBI, seizures, osteoarthritis. Requires supervision and set-up with most ADLs at this time. Interventions: R5 requires supervision assistance from one staff for toileting. It continues; R5 is risk for falls related to history of falls, Bilateral Lower Extremities (BLE) weakness, confusion, Diagnosis TBI, history of Cerebrovascular Accident (CVA)/Trans Ischemic Attack (TIA). 1/30/24 Fall from bed; eating in bed. 3/1/24 Fall in bedroom transferring from wheelchair; laceration to head. 3/8/24 Fall in community bathroom; no injuries. 4/3/24 Fall in bathroom; no injury. 5/20/24 Fall in Dining room while digging through trash. 6/1/24 Fall at nurse's station, picking up a dropped item no injury. 6/22/24 Resident found by bed on buttocks on floor. 6/26/24 Resident found by bed on buttocks on floor. 8/5/24 Resident had witnessed fall, resident slid from w/c while reaching into closet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Care Plan dated 6/25/24 lists the following; Interventions: 2/22/23 Staff to monitor resident while self-propelling outside, 8/01/23 Call light within reach, remind resident frequently to use call light ask for help with transfers, 1/30/24 Staff to ensure resident is up in wheelchair when eating meals, discourage eating in bed, 10/13/2023 Prompted toileting while awake, 10/13/23 Prompt resident to attempt toileting before laying down between meals, 10/19/23 Resident to have non-skid socks on when up in chair and not wearing shoes, 11/20/2023 More frequent checks by staff when resident up in wheelchair, 12/18/23 Bed to be in lowest position when occupied, 12/9/22 Resident reminded to ask for help with transferring, 3/1/24 Staff to prompt resident to lay down earlier in the evening, 3/8/24 Community bathroom door to be locked for staff and visitors only, 4/3/24 Wheelchair breaks to be locked during transfers, 5/30/22 Dycem (non-slip) to wheelchair to prevent sliding, 6/1/24 Staff to assist with keeping items in reach, 6/22/23 Staff assist with putting on footwear properly, 6/22/24 Staff to ensure no clutter in room and reminded resident use call light for assistance, 6/26/24 Staff to ensure bed in locked position with wheelchair by bed in locked position, 8/1/23 Resident to have grip socks on when in bed, 8/5/2022-Therapy to evaluate and treat for safety in wheelchair, 8/5/24 Staff to ensure resident clothes in closet are easy to reach, 9/1/23 Staff to lay resident down between meals and elevate legs to rest, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, needs prompt response to all requests for assistance, be sure call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, Falling Star Program, follow facility fall protocol, to be monitored while outside in back, review information on past falls and attempt to determine cause of falls, record possible root causes. alter remove any potential causes, if possible, educate resident/family/caregivers/IDT (Interdisciplinary Team) as to causes, needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach. R5's Minimum Data Set (MDS), dated [DATE], documents R5 has a severe cognitive impairment and is dependent on staff for toileting, bathing, personal hygiene, and transfers including sit to stand and toilet transfers. R5 is always incontinent of both bowel and bladder. On 8/5/24 at 11:15 AM, R5 was seen being taken to the restroom by V6, Certified Nursing Assistant (CNA). V6 had a gait belt around her own shoulder and body and did not apply it to R5 prior to transfer. V6 pushed R5 to the toilet, and with the wheelchair unlocked, assisted R5 to stand and pivot to the toilet while holding onto R5's arm. After R5 was finished with the toilet, V6 assisted R5 to stand again by holding onto his arm with no gait belt and had R5 hold the rail on the wall by the toilet. After cleaning R5, V6 had R5 sit down in his unlocked wheelchair. At no time did V6 apply the gait belt around R5 or lock the wheelchair for safety during transfer. R5's Fall Risk Assessment, dated 8/5/24, documents R5 was a High Fall Risk. Numerous fall risk assessments were completed since R5's Admission, with each one documenting R5 was a High Fall Risk. The facility's fall log for the past three months, documents R5 has had falls on 6/1/24, 6/23/24, 6/26/24. R5's falls include falling from wheelchair and while using the toilet. On 8/12/24 at 10:00 AM, V2, Director of Nursing (DON), stated I would expect the staff to maintain resident safety, including using a gait belt when needed, and locking the wheelchair prior to transferring a resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Fall Prevention and Management Policy, dated 9/2023, documents This facility is committed to maximizing each resident's physical, mental and psychosocial well- being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. The Facility's Gait Belt Policy, dated 10/27/21, documents To assist with the transfer assistance of a resident. A gait belt will be used with weight-bearing residents who require hands on assistance. 4. Apply gait belt before starting transfer. Secure gait belt around waist. Should allow for 2 fingers to get under the belt. 5. Place resident on edge of bed or chair using good body mechanics. 6. Get close to resident so proper body mechanics are followed with transfer. 7. Lift resident utilizing gait belt. 8. Place resident safely in chair/wheelchair/or bed.

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F 0690 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to provide complete incontinent care for 1 of 5 residents (R5) reviewed for incontinence care in the sample of 41. The findings include: R5's Admission Record, undated, documents R5 was admitted to the facility on [DATE] with diagnosis of Dementia, Cerebral Infarction, Traumatic Brain Injury (TBI), Dysphagia, Falls, Major depressive disorder, COVID, Hypertension, Osteoarthritis, and Convulsions. R5's Care Plan, dated 6/25/24, documents R5 has a potential for Activities of Daily Living (ADL) self-care performance deficit related to Diagnosis TBI, seizures, osteoarthritis. Requires supervision and set-up with most ADLs at this time. Interventions: R5 requires supervision assistance from one staff for toileting. R5's Minimum Data Set (MDS), dated [DATE], documents R5 has a severe cognitive impairment and is dependent on staff for toileting, bathing, personal hygiene, and transfers including sit to stand and toilet transfers. R5 is always incontinent of both bowel and bladder. On 8/5/24 at 11:15 AM, V6, Certified Nursing Assistant (CNA) was seen pushing R5 into the shower room to use the restroom. V6 pushed R5 up to the toilet, then looked back and stated, I guess I need to go get my supplies, I usually have everything sitting on the bedside table. V6 then pushed R5 back out into the hallway while she gathered her supplies, and then pushed R5 back into shower room/restroom. V6 stated I'm not going to lie, I normally don't bring in a table of supplies, I normally have the supplies sitting on the sink (across the room) and go back and forth from toilet to the sink. V6 had a gait belt around her shoulder/body and did not apply it to R5. V6 pushed R5 to the toilet and assisted him to stand and pivot to the toilet, holding onto his arm. After R5 completed having a bowel movement in the toilet, V6 assisted R5 to stand again and had R5 hold the rail by the toilet. V6 used toilet paper and wiped R5's buttocks/anal area several times, then using same soiled gloves, got Peri-Guard cream from the table and applied cream to R5's buttocks. V6 put a clean incontinence brief between R5's legs and fastened it. V6 doffed gloves and assisted R5 to his unlocked wheelchair. There was no cleaning or wiping of R5's front side. When asked if R5's incontinence brief was wet, V6 stated Yes, it was. On 8/12/24 at 10:00 AM, V2, Director of Nursing (DON), stated I would expect the staff to provide complete incontinent care when needed, including having the necessary supplies available, and performing hand hygiene when necessary. The facility's Incontinence Care Policy, dated 4/2024, 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.

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Bria of Mascoutah	901 North Tenth Street Mascoutah, IL 62258

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and observation, the facility failed to properly administer medications to residents, including interpreting prescriber's order and ensuring the resident receives their medications, to meet their needs for 4 of 5 residents (R22, R33, R38, R103) reviewed for medication administration in the sample of 41. Findings include: 1. On [DATE] at 8:35 AM, V10, Registered Nurse (RN) was administering medications to R103. V10 placed a Multi-Vitamin (MVI) in a medicine cup to give to R103. Upon examination of the bottle, the expiration date was ,d+[DATE]. V10 was advised of the expiration date and removed the MVI from the cup. V10 went to the other medication cart and the MVI bottle in that cart was also expired. V10 stated that V2, Director of Nursing (DON), will be going to the local pharmacy to get some. V10 placed a Lisinopril 2.5 MG (milligram) tablet in a medicine cup to give to R103. The physician's order documented 5 MG, when V10 was advised of the physician order, V10 noticed it was incorrect, and stated she would have to verify and correct the order. R103's Physician Order (PO), dated [DATE], documents Multi-Vitamin Tablet. Give 1 tablet by mouth one time a day for supplement. R103's PO, dated [DATE], documents Lisinopril Tablet 5 MG (milligram). Give 0.5 MG by mouth one time a day for HTN (Hypertension). Lisinopril 2.5 MG Tablet. R103's PO, dated [DATE], documents Lisinopril Oral Tablet 2.5 MG. Give 1 tablet by mouth one time a day for HTN. This order was corrected by V10. 2. On [DATE] at 8:45 AM, V10 was administering medications to R22. V10 popped a Lorazepam 0.5 MG tablet out of its package and onto the dirty top of med cart. V10 then picked the tablet up with her hands and put it in the medicine cup, then administered it to R22. R22's PO, dated [DATE], documents Lorazepam Oral Tablet 0.5 MG. Give 1 tablet by mouth every 12 hours as needed for anxiety. 3. On [DATE] at 10:08 AM, R33 was seen lying in his bed with a medicine cup of medications sitting on his bedside table, along with a cup of water. The medicine cup had five pills in one cup, and one pill in another. R33 stated they were cleaning him up when the nurse came in, so she just left them for him to take. R33's Medication Administration Record (MAR), dated [DATE], documents R33 received ASA (Aspirin) 81 MG, Cetirizine 10 MG, Cholecalciferol 1000Units, Ativan 0.5 MG, and Incruse Ellipta inhaler this morning at 8:00 AM. The following medications are also scheduled for 8:00 AM, but was not signed off: Nifedipine 60 MG (check BP at that time), Escitalopram 20 MG, Methadone 10 MG. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33's PO, dated [DATE], documents Aspirin Tablet Chewable 81 MG. Give 1 tablet by mouth one time a day for Prophylaxis. R33's PO, dated [DATE], documents Cetirizine HCl Tablet 10 MG. Give 1 tablet by mouth one time a day for allergies. R33's PO, dated [DATE], documents Cholecalciferol Tablet 1000 Units. Give 1 tablet by mouth one time a day for supplement. R33's PO, dated [DATE], documents Ativan Oral Tablet 0.5 MG (Lorazepam). Give 0.5 MG by mouth two times a day for Anxiety. R33's PO, dated [DATE], documents Nifedipine ER (extended release) Tablet Extended Release 24 Hour 60 MG. Give 1 tablet by mouth one time a day for hypertension. R33's PO, dated [DATE], documents Escitalopram Oxalate Tablet 20 MG. Give 1 tablet by mouth one time a day for depression. R33's PO, dated [DATE], documents Escitalopram Oxalate Tablet 20 MG. Give 1 tablet by mouth one time a day for depression. R33's PO, dated [DATE], documents Methadone HCl (hydrochloride) Oral Tablet 10 MG (Methadone HCl). Give 2 tablets by mouth one time a day for pain. 4. On [DATE] at 10:25 AM, R38 had a bottle of Cinacalcet (Sensipar) 60 MG tablets in a wash basin next to his bed. This bottle appears to be full of pills. On [DATE] at 10:11 AM, R38 sitting up in his bed with a medicine cup of medications, along with a cup of water, seen on his bedside table. The medicine cup had eight pills in it. R38's MAR, dated [DATE], documents R38 received ASA 81 MG, Amlodipine 10 MG, Carvedilol 6.25 MG, Cholecalciferol 125 MCG (microgram), Lasix 80 MG, Losartin 100 MG, Bupropion 75 MG, and Fe (Iron) 325 MG. R38's PO, dated [DATE], documents Aspirin EC Tablet Delayed Release 81 MG (Aspirin). Give 1 tablet by mouth at bedtime for Prophylaxis. R38's PO, dated [DATE], documents Amlodipine Besylate Oral Tablet 10 MG. Give 1 tablet by mouth one time a day related to Acute on Chronic Systolic (Congestive) Heart Failure. R38's PO, dated [DATE], documents Carvedilol Oral Tablet 6.25 MG. Give 1 tablet by mouth one time a day related to Essential (Primary) Hypertension. 38's PO, dated [DATE], documents Cholecalciferol Oral Tablet 125 MCG. Give 1 tablet by mouth one time a day for supplement. R38's PO, dated [DATE], documents Furosemide Oral Tablet 80 MG. Give 1 tablet by mouth one time a day related to Acute on Chronic Systolic (Congestive) Heart Failure. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R38's PO, dated [DATE], documents Losartan Potassium Oral Tablet 100 MG. Give 1 tablet by mouth one time a day related to Essential (Primary) Hypertension. R38's PO, dated [DATE], documents Bupropion HCl Oral Tablet 75 MG. Give 75 MG by mouth two times a day related to Major Depressive Disorder. R38's PO, dated [DATE], documents Ferrous Sulfate Oral Tablet 325 (65 Fe) MG. Give 1 tablet by mouth three times a day related to Anemia. On [DATE] at 10:30 AM, V2, DON, and V14, Regional Nurse Consultant, was advised of cups of medications at R33's and R38's bedside. V14 walked to each room and gathered the medications from R33 and R38 (including the bottle of medications) and stated The nurses should never leave medications at the resident's bedside; they should stay and make sure they take their medications. We will be starting education immediately and will be doing a room-by-room search of medications. On [DATE] at 11:15 AM, V10, RN, stated I did give (R33) his ASA, Cetirizine, Cholecalciferol, and his Methadone (2 pills) in one medicine cup. His Ativan was placed in another medicine cup on its own. I did not give him his Nifedipine or his Escitalopram, I guess I still need to do that yet. I am not sure why I just left his cup of meds there; I usually don't do that. On [DATE] at 11:17 AM, V10, RN, stated I gave (R38) his Amlodipine, ASA, Carvedilol, Cholecalciferol, Lasix, Losartan, Bupropion, Iron, Sertraline, and Sensipar. There should have been nine pills in the medicine cup. If there wasn't, he must have taken one or two of them. (R38) does not like me to stand there and watch him, I usually leave it on the table and will watch him from his doorway. I just got busy and left and did not stay to watch him this time. I think he must have gotten the bottle of medications (Sensipar) from Dialysis because that is not ours and I didn't realize he even had it. On [DATE] at 3:10 PM, V10, stated that she saw V2, and V14, walk by the desk with the cups of medications and she followed them into their office. V10 stated she got the cups from them, put R33's other two medications in the cup, and made sure both residents took their pills. On [DATE] at 10:00 AM, V2, DON, stated I would expect the nurses to ensure the resident receives their medications by watching them take the meds and not leaving them for the resident to take on their own. The Facility's Med Administration Policy, dated ,d+[DATE], documents All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 6. Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident, and time. 7. Read each order entirely. 8. Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring. 9. If there is a discrepancy between the MAR and label, check orders before administering medications. 10. If the label is wrong, send medications to pharmacy for relabeling call pharmacy to send a new label. Verify order with physician. If the MAR is wrong, reenter the order. 11. Verify that the medication has not expired. 13. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. 21. Remain with the resident to ensure that the resident swallows the medication. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Storage of Medications Policy, dated ,d+[DATE], documents Purpose: To provide the staff with guidance on the proper storage of medications. 1. Medication and biologicals must be stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply should only be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. 5. Medications labeled for individual residents should be stored separately from floor stock medications. 8. Over the Counter Medications will use the manufacture expiration date unless otherwise clinically indicated. 11. Outdated, contaminated, or deteriorated medications - and those in containers that are cracked, soiled or without secure closures should be immediately removed from stock and disposed of according to medication disposal procedure. If necessary, medications should be reordered from the pharmacy. 12. Outdated, contaminated, deteriorated medications will be moved from the Medication Carts and placed in pharmacy return bin within the Medication room.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed to remove expired medication from the medication room refrigerator, restock the medication shelf, and medication cart. Findings include: On [DATE] 10:05 AM Medication Storeroom refrigerator was inspected, and the following was found. 1. R47 was observed to have a COVID-19 (Spikevax injection) ,d+[DATE].5ml (milliliters) one time dose with an expiration date of [DATE]. 2. There were two Forteo (Teroparatide) insulin pens inject 0.08ml (20mcg [micrograms] total) under the skin daily labeled with R22's name and the label also documented discard after 28 days after initial use. One had an expiration date of [DATE] and the other had an expiration date of [DATE]. A foil package in the refrigerator was also observed and contained the following medications: 3. Two unopened vials of Novolin R 100 insulin units/ml with expiration dates of [DATE]. 4. One unopened vial of Humulin N insulin 100 units/ml with an expiration date of ,d+[DATE]. 5. One unopened vial of Humulin N insulin 100 units/ml with an expiration date of ,d+[DATE]. 6. Two unopened vial of Humulin R insulin 100 units/ml with an expiration date of ,d+[DATE]. 7. One unopened vial of Novolin N insulin 100 units/ml with an expiration date of [DATE]. 8. Daptomycin for injection 500mg per vial single-dose vial with an expiration date of ,d+[DATE]. On [DATE] at 10:15 AM, the medication storage room stock medications were inspected, and the following was found: two bottles of Aspirin 81mg with an expiration date of ,d+[DATE]. On [DATE] at 10:20 AM, V13, Licensed Practical Nurse (LPN) verified the medications had expired. She said the insulin found in the refrigerator if it didn't have a resident's name on it was for facility use. On [DATE] at 10:19 AM V1, Administrator stated the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) are to check the med storage room, refrigerator every month and she would expect the nurses to check the date on the medication before putting it on the medication cart and dispose of it if it needed to be disposed of. 44967 (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:35 AM, V10, Registered Nurse (RN) was administering medications to R103. V10 placed a Multi-Vitamin (MVI) in a medicine cup to give to R103. Upon examination of the bottle, the expiration date was ,d+[DATE]. V10 was advised of the expiration date and removed the MVI from the cup. V10 went to the other medication cart and the MVI bottle in that cart was also expired. V10 stated that V2, Director of Nursing (DON), will be going to the local pharmacy to get some. R103's Physician Order (PO), dated [DATE], documents Multi-Vitamin Tablet. Give 1 tablet by mouth one time a day for supplement. The Facility's Storage of Medications Policy, dated ,d+[DATE], documents Purpose: To provide the staff with guidance on the proper storage of medications. 1. Medication and biologicals must be stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply should only be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medication. 5. Medications labeled for individual residents should be stored separately from floor stock medications. 8. Over the Counter Medications will use the manufacture expiration date unless otherwise clinically indicated. 11. Outdated, contaminated, or deteriorated medications - and those in containers that are cracked, soiled or without secure closures should be immediately removed from stock and disposed of according to medication disposal procedure. If necessary, medications should be reordered from the pharmacy. 12. Outdated, contaminated, deteriorated medications will be moved from the Medication Carts and placed in pharmacy return bin within the Medication room. The Facility's Med Administration Policy, dated ,d+[DATE], documents All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Guideline: 6. Check medication administration record prior to administering medication for the right medication, dose, route, patient/resident and time. 7. Read each order entirely. 8. Remove medication from drawer and read label three times; when removing from drawer, before pouring and after pouring. 9. If there is a discrepancy between the MAR and label, check orders before administering medications. 10. If the label is wrong, send medications to pharmacy for relabeling call pharmacy to send a new label. Verify order with physician. If the MAR is wrong, reenter the order. 11. Verify that the medication has not expired. 13. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. 21. Remain with the resident to ensure that the resident swallows the medication.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44967 Based on interview, observation and record review, the facility failed to perform proper hand hygiene and/or the wearing of gloves while plating food and failed to check and maintain the temperatures of the food, including all diets (regular diets, special diets, and pureed foods), prior to serving the residents to prevent contamination and foodborne illness. This failure has the potential to affect all 50 residents living in the facility. The findings include: On 8/5/24 at 12:10 PM, Upon walking into kitchen, V8 (Cook) was already starting to plate food with no gloves on. When asked if temperature checks were done, V8 stated I checked them when I took them off the stove. When asked to check temperatures: Turkey was at 160 degrees Farenheight (F.), Gravy at 163 degrees F., Mashed potatoes at 160 degrees F., [NAME] beans at 192 degrees F., Cream corn at 135 degrees F., and Mechanical Soft turkey was reading 120 degrees F. The Mechanical Soft food was put in the microwave by V7 (Dietary Manager-DM), for 15 seconds, he rechecked the temperature which was reading 135 degrees F. The Pureed food was temped at 113 degrees F. and was put in the microwave and still temped at 136 degrees F. V9 (Dietary District Manager) took the pan of Pureed food and put it on the stove top and heated up, then re-temped until it was at 176 degrees F. On 8/5/24 at 12:25 PM, V7 stated (V8) did check the temp when she got the food out of the oven but did not check it before she began plating the food. On 8/5/24 at 12:30 PM, V9 stated The cook is supposed to check the temperatures of the food once out of the oven or stove, then again before plating the food. The kitchen's temperature sheet, documents temps were taken after the food was removed from the oven, but no other times were documented (see attachment). On 8/5/24 at 12:45 PM, V8 went to the back of kitchen, and brought a tray cart to the front to put room trays on, returned to the serving line and continued to plate the food with no hand hygiene done. V8 was seen multiple times leaving the serving station to get different items in the kitchen, then returning to the serving line and continued to serve food with no hand hygiene done. On 8/5/24 at 12:50 PM, V8 walked from serving line to back of the kitchen to get a bag of gluten free bread for a resident. V8 reached in with her bare hands and grabbed a piece of bread. V7, DM, noticed V8 doing this and advised her that she needed to get tongs to use on the bread. V8 dropped the bread back into the bag and then used tongs to get the piece of bread out and put it on a resident's plate. On 8/12/24 at 9:55 AM, V1 (Administrator) stated I would expect the kitchen staff to check the temperatures of the food when required, especially before plating the food to be served to the residents. I would expect the kitchen staff to do hand hygiene as necessary. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/12/24 at 10:10 AM, V7 stated I saw just what you saw and couldn't believe she was not doing what she was supposed to be doing. I would expect the cook to check the food temperatures when removing from the stove, prior to plating the food, then again at the end. The cook does not necessarily need to wear gloves while serving food if they are using utensils. I do expect them to do hand hygiene any time they leave the food line and prior to the serving of the food. I also expect the cook to use proper utensils while serving the food, including getting bread out of the bag. During this lunch observation, at no time was any staff member in the kitchen seen wearing gloves, including the cook who was serving/plating the food with no gloves on, and there were no further temperatures done on the food line while serving lunch to the residents. The Facility's Food Preparation Policy, dated 2/2023, 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(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 F and/or less than 135 F, or per state regulation. 10. Time/Temperature Control for Safety (TCS) hot food items will be cooked to a minimum internal temperature, as follows: All poultry and stuffed foods 165 F (<1 second instantaneous). 11. When hot pureed, ground, or diced food drop into the danger zone (below 135.), the mechanically altered food must be reheated to 165. for 15 seconds if holding for hot service. 12. When reheating, foods will be rapidly heated to 165 F for 15 seconds. If the food is not reheated within 2 hours it must be discarded. 13. All foods will be held at appropriate temperatures, greater than 135 F (or as state regulation requires) for hot holding, and less than 41 F for cold food holding. 14. Temperature for TCS foods will be recorded at time of service and monitored periodically during meal service periods. 15. All staff will use serving utensils appropriately to prevent cross contamination. The Facility's Meal Distribution Policy, dated 2/2023, documents Proper food handling techniques to prevent contamination and temperature maintenance controls will be used for point-of-service dining. The Resident Census and Conditions of Residents, CMS 671, dated 8/5/24, documents that the facility has 50 residents living in the facility.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 44556 Based on observation, interview, and record review the facility failed to provide 80 square feet of floor space per resident bed for 9 of 50 residents (R5, R11, R15, R19, R20, R22, R32, R33, and R103) reviewed for room size in the sample of 41. Findings include: On 08/12/24 at 10:19 AM V1 (Administrator) stated there has been no changes of the measurements and accuracy of the facility's waivered resident room numbers and certifications. V1 stated there were 5 rooms on the 100 hall and all rooms were Medicare and Medicaid certified and provide 77.5 square feet per resident per bed. R5, R11, R15, R19, R20, R22, R32, R33, and R103's rooms were measured on the 100 hallway and each room measured was less than 80 square feet per resident. Observations made throughout the survey from 08/05/24 through 08/12/24 demonstrated no concerns or complaints vocalized by residents in relation to waivered room size. On 08/06/24 at 11:00 AM, during the resident group meeting no residents voiced any complaints or concerns regarding room size. The facility provided a list of residents affected by the room size and (R5, R11, R15, R19, R20, R22, R32, R33, and R103) were all documented as receiving a room waiver. The Resident Census and Conditions of Residents, CMS 671, dated 8/5/24, documents that the facility has 50 residents living in the facility.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on interviews, observations, and record reviews the facility failed to promote a pest free environment by not removing flies from resident's rooms for 6 out of 6 residents, (R6, R103, R13, R46, R22, R11), reviewed for pest control in a sample of 41. Findings include: On 8/5/24 at 9:30 AM, R6 has flies her in room, R6 stated the flies are bad here. On 8/5/24 at 9:35 AM, R103 had flies in his room; R103 stated the flies are a [NAME] to him and have been bad. On 8/5/24 at 9:58 AM, R46 had flies in her room and there is a fly swatter on her bedside table. On 8/5/24 at 10:02 AM, R13 had flies in her room and a fly swatter. R13 stated the flies are bad here and complained about them but nothing has been done. On 8/5/24 at 10:15 AM, R11 has flies in her room. R11 stated the flies have been horrible for 3-4 months now and because she has to use a bedside commode, the flies get worse. R11 stated she has complained about the flies, but nothing has been done. On 8/6/24 at 10:30 AM, R22 has flies in her room. R22 stated because she has to use a bedside commode, the flies seem to be accumulating more because the facility does not clean the commode frequently, it is left dirty, and she hates it. R22 stated she feels horrible when she is left in a room with a dirty commode and flies all around. On 8/8/24 at 9:00 AM, R11 was eating her breakfast on the side of her bed with flies and a full commode filled with stool, urine, and tissues. On 8/8/24 at 9:15 AM, V2 (Director of Nursing-DON) observed R11's full commode and flies in her room. On 8/8/24 at 11:15 AM, V15 (Maintenance Director) stated we don't have many flies here, maybe one or two and we haven't had to do much. V15 stated we have put up sticky fly traps in the hallway corners but nothing in the resident's room. V15 stated he was unaware that some residents had fly swatters in their rooms. The last receipt from pest control services for Monthly Commercial Pest Control was dated 7/17/2024. The facility's Pest Control policy dated 10/2017, documents, This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.