

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/10/2024
NAME OF PROVIDER OR SUPPLIER  Bria of Alton		STREET ADDRESS, CITY, STATE, ZIP CODE  3523 Wickenhauser Alton, IL 62002	

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 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42108</p> <p>Based on interview and record review the facility failed to arrange a medically necessary appointment transport for 1 of 3 (R16) residents reviewed for dialysis in the sample of 18. This failure resulted in R16 missing his appointment to treat a clogged dialysis shunt, which in turn created ineffective dialysis procedures.</p> <p>Findings include:</p> <p>R16's Care Plan, dated [DATE], documents Dialysis: Resident has potential for impaired renal function secondary to Dialysis due to ESRD (End Stage Renal Disease); Assist with arranging transportation to and from dialysis center, check arteriovenous fistula/shunt for bruit and thrill to assess for arterial blood flow every shift, inspect access site dressing after dialysis and apply pressure if bleeding occurs. If bleeding does not stop or restarts, contact MD (Medical Doctor) and/or dialysis clinic, Notify MD and/or dialysis clinic PRN (as needed) of complications, Notify MD of weight gain, and/or fluid volume excess ( sudden, weight gain, increased BP(blood pressure), full bounding pulse, jugular vein distention, SOB (shortness of breath), moist cough, abnormal breath sounds, and edema), Observe access site for s/s (signs/symptoms) of infection: redness, drainage, swelling, pain and displacement every shift. Report changes in neurological status (E.g.: altered LOC (level of consciousness), headache, visual or pupillary changes, restlessness, seizures), Review post treatment sheets.</p> <p>R16's Minimum Data Set, dated dated [DATE], documents that R16 is cognitively intact.</p> <p>R16's Dialysis progress note, dated [DATE] at 9:11 AM, documents AVF (arteriovenous fistula) RUA (right upper arm)- primary cannulation without difficulties/issues. Secondary &amp; Tertiary cannulation, both times there was a flash, blood moved down the line by itself, unable to push or pull, needles were readjusted without success. RN (registered nurse) called Vascular Institute, advised that access be rested and try again tomorrow, if no success will have to come in, possible re-insert CVC (Central Venous Catheter).</p> <p>R16's Progress Note, dated [DATE] at 10:22 AM, documents Nurses Notes Note Text: resident has an appointment at (Regional hospital) with the vascular unit at 8am tomorrow to have his fistula unclogged. transportation is aware.</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: 145427
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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R16's Progress Note, created date [DATE] at 1:10 PM and effective date [DATE] 1:08 PM, documents Nurses Notes Late Entry: Note Text: Resident attended appointment at Vascular Institute at (Regional Hospital) New cath (catheter) put in due to infiltration of fistula. Waiting for the edema to subside and will have a fistulagram on [DATE] to see if it has remedied itself.</p> <p>R16's (Regional Hospital) History and Physical, dated [DATE], documents reason for admission: Pt (patient) is a [AGE] year-old who has a past medical history of Anemia, Chronic obstructive pulmonary disease, Cognitive communication deficit, ESRD (end stage renal disease) on dialysis, ESRD on dialysis, Essential hypertension, and Hyperlipidemia was transferred from (local hospital) for evaluation by vascular surgery for his non-working dialysis AV fistula. He gets his dialysis daily except Saturday. He had his full dialysis on Wednesday. Yesterday when he was having his dialysis his AV fistula stopped working and he couldn't complete his dialysis. As per Dialysis nurse his fistula was clotted. For which he went to (local) ER (emergency room ) for evaluation today and was transferred to (hospital).</p> <p>R16's Progress Note, dated [DATE] at 9:07 PM, documents Nurses Notes Note Text: Resident was readmitted to the facility at 7:30 pm. from (Regional Hospital). Arrived via stretcher and accompanied by 2 EMT (Emergency Medical Technicians). Returned to room. Resident is alert and oriented and able to make needs known. No respiratory distress noted. Assessed resident and noted his new fistula in his RUE. No s/sx (signs and symptoms) of pain or discomfort. No irritation noted. Resident is afebrile. (, d+[DATE]-97XXX[DATE]-96% RA (room air). Resident able to move about independently. Resting at this time.</p> <p>R16's Progress Note, dated [DATE] at 12:17 PM, documents Nurses Notes Note Text: pt (patient) appt (appointment) by dialysis nurse at (Vascular Clinic) will be rescheduled. pt being sent out to (local hospital) NPO (nothing by mouth) for eval of lt (left) chest fistula for an eval and possible intervention to function properly. pt up ad lib, ,d+[DATE] last bp (blood pressure) at noon. picked up via (local hospital) ambulance to (local hospital) via x2 staff members. pt took his phone charger and his wallet with him.</p> <p>R16's Progress Note, dated [DATE] at 4:40 PM, documents Nurses Notes Note Text: Resident returned to the facility in good spirits. No c/o (Complaints of) voiced, denies pain. Resident had lab work while there. Looks like he has some up and coming appointments.</p> <p>On [DATE] at 9:40 AM V27, Registered Nurse, stated that R16 catheter was clogged and had been sent to the emergency room . V27 stated that there was an attempt to unclog without success. V27 stated at that time R16 was evaluated and an appointment was made with the vascular clinic. V27 stated that a week later R16 was sent back to the hospital because the facility did not have transportation to send him to his appointment that would have fixed the clog. V27 stated that the hospital could not do anything because R16 was not admitted . V27 stated that R16 was assessed and sent back to the facility. The catheter remained clogged. V27 stated that it is inappropriate to send a patient to the emergency room because you don't have transportation for his doctor's appointment. V27 stated that the facility sent the patient to the ER to handle it. V27 stated that this is R16's lifeline and not having appropriate dialysis can lead to his death. V27 stated that this is inappropriate level of care and neglectful.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:40 AM V25 stated that R16 is a dialysis patient of theirs. V25 stated that R16 has two access points, and both are compromised. V25 stated that this is a big concern because they can't dialyze R16 appropriately. V25 stated that R16 had an appointment at the vascular clinic and that appointment was missed due to transportation issues. V25 stated that R16's kidneys don't filter blood the way they should. As a result, wastes and toxins build up in his bloodstream. Dialysis removes waste products and excess fluid from the blood because his kidneys can't. V25 stated that this is a serious problem and can be life threatening.</p> <p>On [DATE] at 12:00 PM V4, Nurse Practitioner, stated that she was made aware of R16 access being clogged. V4 stated that they are able at this time to perform dialysis. V4 stated that they are not able to remove all of the fluid but believes that may be due to R16's blood pressure. V4 stated that it is important that R16 has his CVC fixed. V4 stated that she has informed V26 to continue to communicate with V4 about R16's dialysis and the facility is in the process of getting an appointment. V4 stated that the residents on dialysis have such a high acuity. V4 stated that she can't do much if they don't get them to the appointment.</p> <p>On [DATE] at 12:12 PM V2, Director of Nursing, stated that R16 was having some problems with his access. V2 stated that R16 had been out to the hospital and had a new catheter placed. V2 stated that at some point the dialysis staff made an appointment for R16 to be seen at clinic in Missouri. V2 stated that the dialysis staff did not communicate the appointment appropriately to the V23 so that transportation could be set up. V2 stated that when he became aware that R16 missed the appointment he notified V4 and R16 was sent to the hospital for evaluation. V2 stated that the appointment was cancelled due to transportation issue.</p> <p>On [DATE] at 1:09 PM V24, dialysis Registered Nurse, stated that R16 is a patient of theirs. V24 stated that there have been issues with R16 missing appointments. V24 stated that currently R16's ability to remove waste and toxins from his body is compromised. V24 stated that R16 has a shunt in right arm that has been clogged and no access at this time. V24 stated that she is aware that R16 has gone to the hospital. V24 stated that the problem with that is the hospital will not do anything with the graft to the shunt. V24 stated that hospital prefer to leave that to those that specializes in this. V24 stated that so sending R16 to the hospital may not help. V24 stated that R16 has not been to the institute since [DATE]. V24 stated that R16 went to the hospital. V24 stated that they share the hospital but is a separate entity. V24 stated that R16 had catheter placed while there. V24 stated that they were informed by the dialysis that this is not working and that they are getting less and less results. V24 stated that this is a serious problem because this is his only lifeline. V24 stated the appointment was set for replacement and R16 did not show. V24 stated that this is a problem because if this continues R16 could die.</p> <p>On [DATE] at 7:45 AM R16 stated that he is aware of the issues with his shunt site. R16 stated that it is blocked and can't be used. R16 stated that he was supposed to go to the clinic but was not able to because of transportation. R16 stated that V23 takes him if she doesn't have any appointments, or he goes by ambulance. R16 stated that the facility sent him to the hospital and the hospital did not do anything for him. R16 stated that he was told that this is a specialty and must be handled by the right people. R16 when he went to (Regional Hospital) they didn't address the clog at all. R16 stated that the put a line in him and told him this was temporary and that he has to get to the clinic to get his access fixed. R16 stated that when he was to go to his appointment the facility sent him to (local hospital) instead. R16 stated that they didn't do anything there either. R16 stated that the catheter that he has in now doesn't work well either.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42108</p> <p>Based on observation, record review, and interview, the facility failed to ensure food was served in the appropriate portions for 8 of 13 (R2, R7, R8, R9, R10, R11, R12, and R13) residents reviewed for food services.</p> <p>Finding includes:</p> <p>1. The facility menu Week 2 Wednesday documents Supper: Chicken Nuggets (7 ea (each)= 3 oz (ounces)pro (protein)), Barbecue Sauce (1 Tbsp (tablespoon)), Crispy French Fries (4 oz spdl = 1/2 cup), Seasoned Mixed Vegetables (#8 scoop= 1/2 cup), Powdered Sugar Brownie (1 piece), 2% Milk (8 oz), Coffee/Hot Tea (6 oz), Condiments (1 ea).</p> <p>R2's Fall Assessment, dated 8/23/2024, documents that R2 is alert and oriented.</p> <p>The facility provided a roster and identified R2 as interviewable.</p> <p>On 9/3/2024 at 11:00 Am R2 stated that he has been at the facility for 7 days. R2 stated that the food is horrible and that the portion sizes are small. R2 stated that the facility served chicken nuggets one evening for supper. R2 stated that he was given 4 nuggets and a few fries. R2 stated that when asked if he could have more, he was told that there wasn't any. R2 stated that he was not given any vegetables and was informed that he can't have vegetables with all his meals. R2 stated that today he was informed that he can get so much a day and if they put green and red peppers in the eggs it counts towards the overall vegetable for the day. R2 stated that he is a large man, and he can't live off of the amount of food given.</p> <p>2. R12's Minimum Data Set, dated dated [DATE], documents that R12 has moderate cognitive impairment.</p> <p>R12's Dietary Assessment, dated 8/30/2024, documents that R12 is at moderate risk for weight loss.</p> <p>On 9/5/2024 at 9:37 AM R12 stated that the portion sizes are small and sometimes they run out. R12 stated that the cook, V21, is good and will try to get me something else but there may not be anything. R12 stated that the night of the chicken nuggets was a joke. R12 stated that he got a few nuggets and maybe 4 or 5 fries. R12 stated that he did not receive any vegetable. R12 stated that they bring snacks at the nurse's station, but he doesn't get any. R12 stated that he guesses he would have to ask for it.</p> <p>On 9/3/2024 at 11:55 AM V21, Cook, stated that she was the cook that served the chicken nugget meal. V21 stated that she gave 5 nuggets for regular and 6 for double portions. V21 stated that she doesn't run out of food because she has the alternate but sometimes the main meal is out, and it is substituted with the alternate.</p> <p>On 9/3/2024 at 12:06 PM V22, Cook, stated that they run out of food all the time.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. The facility menu Week 3 Tuesday documents Lunch: Tender Pork Roast (3 oz pro), Bread Dressing (#8 scoop= 1/2 cup), California Blend Vegetables (#8 scoop= 1/2 cup Banana (1 ea), Bread (1 slice), Margarine (1 tsp), Decaf Coffee/Hot Tea (6 oz) Condiments (1 ea),</p> <p>On 9/3/2024 at 12:08 PM to approximately 12:40 PM the noon meal service in the Main Dining Room was observed. Dietary staff were serving food from the steam table in the Dining Room. V21 was using tongs to pick up a serving of the pork meat entree. R7, R8, R9, R10, R11, and R12 were served regular pork and bread dressing. At no time was the meat weighed. Using a #6 scoop V21 partially filled scoop when serving. R7, R8, R9, R10, R11, and R12 received various portion sizes of pork and bread dressing ranging from small to large.</p> <p>4. R13's MDS (minimum data set), dated 7/29/2024, documents that R13 is cognitively intact.</p> <p>On 9/3/2024 at 10:53 AM R13 stated that the food is not good. R13 stated that they don't get enough food. R13 stated that they must spend money on door dash and get food because there is none. R13 stated that they are paying over \$1000 a month and they should get a good meal and enough food.</p> <p>On 9/3/2024 at approximately 1:15 PM V21 stated that she was not sure of what portion size to give but was just told 3oz. V21 stated that when serving she does not have a way to measure the portion size of the pork. V21 stated that she tries to make sure that everyone gets enough.</p> <p>On 9/3/2024 at approximately 2:10 PM V1, Administrator, stated that they do not have a policy that relates to serving appropriate portion sizes.</p>		