

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 09/24/2024
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 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108</p> <p>Based on observation, interview, and record review the facility failed to provide toileting to promote resident's dignity for 1 of 3 residents (R3) reviewed for dignity in a sample of 8. This failure caused R3 to be incontinent and feel helpless, ashamed, embarrassed, depressed, and demeaned.</p> <p>Findings include:</p> <p>R3's Care Plan, dated 9/3/2024, does not address R3's toileting.</p> <p>R3's Minimum Data Set, dated [DATE], documents that R3 is cognitively intact, frequently incontinent of urine and bowel and independent with toileting.</p> <p>On 9/17/2024 at 12:14 PM V17, R3's sister, stated that R3 is her brother. V17 stated that she is his power of attorney but that R3 makes his own decisions. V17 stated that her brother has called her and told her of the horrible conditions of his care. V17 stated that R3 was embarrassed. V17 stated that R3 wants to go to the bathroom but the facility had no way to get him on a toilet. V17 stated that R3 had to lay in his own body fluids. V17 stated that this had to be humiliating. V17 stated that it's one thing to have to go on yourself because you can't control it but to have to because they have no way to take you to the toilet is unacceptable.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/17/2024 at 1:56 PM R3 stated that he was originally at home. R3 stated that he became ill and was in the hospital for some time. R3 stated that he was then transferred to a rehab facility. R3 stated that at that facility he received Therapy almost daily. R3 stated that he had regained some of his strength back. R3 stated that at the facility they had a handicap accessible bathroom, and he was able to hold on to the rail and get on the toilet. R3 stated that once his insurance ran out and he became Medicaid he was then transferred to this facility. R3 stated that the staff would not help him. R3 stated that he is a large and wide man. R3 stated that he is obese and weighs close to 400lbs (pounds). R3 stated that he can't get into the bathroom at this facility. R3 stated that his wheelchair won't go through the bathroom door. R3 stated that he was given an adult bried and told to go in it. R3 stated that they brought in a commode but because he was not trained, he couldn't use it. R3 stated that he did not like going to the bathroom on himself. R3 stated that this is ridiculous. R3 stated I need help that's why I came there, and they did not want to help me. R3 stated that he was transferred in a lift and because of this he could not use a toilet. R3 stated that the shower room on the hall is big but there isn't a toilet. R3 stated that he felt embarrassed, and it was demeaning. R3 stated that I know I'm a big man, but they should have a place where I can use the bathroom. R3 stated that they didn't even try. R3 stated How do you fight that. I felt helpless and ashamed." R3 stated that he is disgusted with himself that this is now his life. R3 stated To be told to use the diaper and then have to. I'm not sure how to handle that. R3 stated that he would put his call light on, and they never come. R3 stated that he would go on himself. R3 stated Ridiculous. R3 stated that the website says they have all these things and services, but they don't. R3 stated I want to get better and go home. How am I supposed to do that.</p> <p>On 9/17/2024 at 12:07 PM V11, Certified Nurse's Assistant (CNA), stated that she did not take R3 to the bathroom or use the bedside commode. V11 stated that R3 was incontinent. V11 stated that R3 would tell them when he was wet.</p> <p>On 9/18/2024 at 9:40 AM V10, CNA, stated that R3 had a commode in his room but it was not used. V10 stated that it still had the plastic on it.</p> <p>On 9/19/2024 at 3:47 PM V18, CNA, stated that she took care of R3, and he was a full body mechanical lift. V18 stated that R3 was incontinent and not taken to the bathroom. V18 stated that R3 did not use a urinal or bedpan. V18 stated that R3 uses a full body mechanical lift to transfer. V18 stated that residents that use the full body mechanical lift are usually incontinent. V18 stated that R3's wheelchair could not fit through the bathroom.</p> <p>On 9/19/2024 at 3:49 PM V19, CNA, stated that she did not care for R3 but was familiar with R3 and his care. V19 stated that he used a full body mechanical lift. V19 stated that the full body mechanical lifts do not fit in the bathroom, they are too big. V19 stated that they give the residents urinals and bed pans.</p> <p>On 9/24/2024 3:37 PM V1, Administrator, stated that she expects her staff to assist residents to the toilet. V1 stated that she expects if the resident can't use the toilet to be provided with a urinal and bedpan.</p> <p>(continued on next page)</p>		

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F 0550 Level of Harm - Actual harm Residents Affected - Few	<p>The facility's Resident Rights policy, dated 2/2024, documents The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preference. It continues PROCEDURE: I. The facility will assess and interview resident for the need to make reasonable accommodations such as: Room set-up and Adaptive devices necessary to maintain/restore resident at their highest level of functioning.</p> <p>The facility's Activity of Daily Living policy, dated 9/2023, documents GUIDELINE: 2. A program of assistance and instructions in ADL skills is care planned and implemented. 3. Assistive devices and adaptive equipment are provided by Occupational Therapy. It also documents D. Elimination: b. Adaptive equipment, assistance and instruction are given as required.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108</p> <p>Based on interview and record review the facility failed to obtain consent for an antipsychotic medication prior to administering antipsychotic and antidepressant medication for 2 of 3 residents (R3, R4) reviewed for informed treatment/treatment decisions in a sample of 8.</p> <p>Findings include:</p> <p>1. R3's Care Plan, dated 9/3/2024, documents PSYCHOTROPIC MEDS: (R3) requires the use of psychotropic medication (Zoloft) to assist with managing mood and behavior r/t (related to) Depression.</p> <p>R3's Minimum Data Set, dated [DATE], documents that R3 is cognitively intact.</p> <p>R3's Physician Order Sheet (POS) documents Sertraline HCl Oral Tablet 25 MG (Sertraline HCl)</p> <p>Give 1 tablet by mouth one time a day for major depressive order for 90 Days.</p> <p>R3's Medication Administration Record (MAR) and Treatment Administration Record (TAR) documents that R3 received Zoloft 25 mg from 8/31/2024 to 9/13/2024.</p> <p>On 9/17/2024 at 11:00 AM a review of R3's electronic health record (EHR) was reviewed. No psychotropic consent documented in chart for Zoloft.</p> <p>On 9/17/2024 at approximately 1:20 PM V2, Director of Nursing, provided a blank Consent for Psychotropic form. V2 stated that the consents are in the EHR.</p> <p>R3's Consent for Psychotropic Medication, dated 9/17/2024 at 2:31 PM, documents verbal consent received 8/23/2024.</p> <p>On 9/17/2024 at 1:56 PM R3 stated that he did not give the consent to take any antidepressant. R3 stated that he was not informed of any risk vs benefits, and he did not give verbal or written consent for this medication. R3 stated that he found out by accident. R3 stated that the nurse told him that she had forgot his antidepressant. R3 stated at that time he asked when he started taking it and that he was not aware of that he was taking the medication.</p> <p>On 9/17/2024 at approximately 3:15 PM V1, Administrator, stated that once checked, after question of surveyor, it was noted that there were multiple residents that did not have consent documentation. V1 stated that she educated V2, and the consent documentations were put in place. V1 stated that she is aware that this is a problem and is in the process of trying to correct it. V1 stated that V2 is new and is still learning his role at the facility. V1 stated that she instructed V2 to get the consents and document in computer and assure that they put today's date as this is the date it was completed.</p> <p>On 9/18/2024 at approximately 9:15 AM V13, LPN, stated that most of the residents in the facility are on an antipsychotic. V13 stated that when the medication is ordered a consent is received from the resident or the family in order for the medication to be given.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. R4's Care Plan, dated 8/20/2024, does not address R4's psychotropic medication use.</p> <p>R4's MDS, dated [DATE], documents that R4 is cognitively intact.</p> <p>R4's POS, documents 9/12/2024 Trazodone HCI Tablet 50 MG Give 1 tablet by mouth at bedtime related to Major Depressive Disorder, Single Episode Mild. 9/12/2024 There is a black box warning associated with this order. 9/12/2024 Duloxetine HCI Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth one time a day related to Major Depressive Disorder, Single Episode Mild. 9/12/2024 There is a black box warning associated with this order.</p> <p>On 9/18/2024 at 12:29 PM R4's EHR was reviewed. No psychotropic consent documented in chart.</p> <p>On 9/18/2024 at 9:52 AM R4 stated that he is new to the facility. R4 stated that he does not take any antidepressants and antipsychotic medication. R4 stated that he has not given any verbal or written consent for those types of medication. R4 stated that he saw a doctor at the facility and told them that he was having some problems sleeping. R4 stated that he was not told that he was getting new medication. R4 stated that no one has explained any adverse reactions I think that's what it's called to him. R4 stated that he assumed his medication from the hospital followed him here.</p> <p>The facility's Psychotropic Medication Program, dated 9/2022, documents GENERAL: The second purpose of this process is to ensure the resident is evaluated and the indication for the medication is documented within the medical record including but not limited to the nursing staff, social services, activities, and the physician. Also, the resident and or resident representative are aware of the potential side effects and the facility obtains an informed consent for the use of the psychotropic medication.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108</p> <p>Based on interview and record review the facility failed to provide tracheostomy (trach) care for 1 of 1 resident (R3) reviewed for trach care in a sample of 8.</p> <p>Findings include:</p> <p>1. R3's Care Plan, dated 9/3/2024, documents R3 is at risk for complications r/t (related to) tracheostomy placement (trach tube) #6. It continues to document that staff should assess for signs and symptoms (s/s) of infection such as erythema, swelling, unusual drainage or odor or presence of a fistula, at noc (night) place on a Venturi mask with 28 % per trace collar at 10-15 Umin. Perform trach care as ordered and as needed. Trach collar with 28% humidified air continuous.</p> <p>R3's Minimum Data Set, dated [DATE], documents that R3 is cognitively intact.</p> <p>R3's Medication Administration Record (MAR) and Treatment Record (TAR) documents 8/28/2024 Change Trach collar twice weekly and as needed The MAR documentation of R3's trach collar changes for August and September 2024. In addition, the order, dated 8/28/2024, documents Cleanse Trach every shift using sterile technique does not document procedure completed on 8/29, 8/30, 9/4, and 9/9 7a-&p shift, 9/2, 9/3, 9/4, 9/8, and 9/9/2024 for the 7p-7a shift.</p> <p>R3's Progress Note, dated 8/23/2024, documents that R3 was admitted to the facility with trach. The Progress Note documented that the trach was to be capped in day and placed on mask at night.</p> <p>R3's Progress Note, dated 8/26/2024 at 3:26 PM, documents Nurses Notes Note Text: resident noted to be SOB (shortness of breath) out in the dining on 2 liters of O2 (oxygen), resident stats (oxygen saturation levels) were 75 (percent) upon initial assessment. resident was brought back to his room and was given a prn duo neb, residents stats came up to 84% on 2 liters after about 5 mins resident stats increased to 87% then dropped back down to 82%, DON (Director of Nursing) was present in room and contacted the providers whom gave orders to place resident on 10liters of O2 for via trach collar, after about 10mins residents O2 is back up to 87% , will continue to monitor.</p> <p>R3's Progress Note, dated 8/27/2024, documents that trach care was performed. No documentation in Electronic Health Record of Trach care performed prior to 8/27/2024.</p> <p>R3's Progress Note, dated 9/3/2024 at 21:22 Nurses Notes Note Text: Cleaned resident's inner cannula with aseptic technique and sterile water. Tolerated well with no complaints of pain. Has yellow drainage around outer part of dressing changed. On L of oxygen per nasal cannula.</p> <p>R3's Progress Note, dated 9/9/2024 at 4:57 PM, documents Nurses Notes Note Text: Trach care provided. NP (Nurse Practitioner) made aware of discolored discharge and redness ordered CXR (chest x ray) and sputum culture. Res (resident) made aware.</p> <p>R3's Progress Note, dated 9/12/2024 at 6:28 AM, documents Nurses Notes Note Text: Trach care and breathing tx (treatment) c/o (complaint of) pain, still awaiting sputum culture ordered by NP.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's Progress Note, dated 9/13/2024 at 1:46 PM, documents Nurses Notes Note Text: Res sent out to (local hospital) r/t (related to) labored breathing, c/o pain at trach site, and trouble breathing. Res trach site reported to be coming loose when eating, red, warm to discolored secretions. (V20) NP (Nurse Practitioner) made aware.</p> <p>R3's Local Hospital Records, dated 9/13/2024, documents Chief Complaint Patient presents with Trach Issue History of respiratory failure, tracheostomy. Patient has green sputum coming from the tracheostomy site. His tracheostomy tube is capped. Patient has chronic shortness of breath.</p> <p>On 9/17/2024 at 1:56 PM R3 stated that he was admitted to the facility with his trach. R3 stated that it took over a week before he received trach care. R3 stated that his trach should be cared for a couple of times a day. R3 stated that because he didn't have any trach care he became short of breath and his oxygen levels plummeted. R3 stated that he received trach care that day. R3 stated that the sometimes receive trach care but it is not every day and it's not more than once in that day. R3 stated that he had drainage coming from his trach and that it smelled. R3 stated that the people of that facility were scared to take care of the trach. R3 stated that when he was up his trach is capped but he is supposed to be placed on a mask at night and this has not happened. R3 stated that his trach stays capped. R3 stated that he is afraid that he will not make it out of that facility. When asked what he means by that statement R3 stated that he is afraid that he will die there because the staff won't and does not know how to take care of him.</p> <p>On 9/17/2024 at approximately 12:00 PM V12, Licensed Practical Nurse, LPN, stated that she has care for R3 and has provided him with trach care. V12 stated that she can't speak for anyone else but when she is at the facility, she performs trach care. V12 stated that R3 has complained that he was not receiving trach care, but she is not sure of why or if that was true.</p> <p>On 9/18/2024 at V13, LPN stated that she has been assigned to R3. V13 stated that she has worked with him on midnights. V13 stated that she has not performed trach care on R3. V13 stated that R3 would do it himself. V13 stated that R3 had oxygen on with his catheter and cannot say that he had a mask on.</p> <p>On 9/24/2024 at 3:37 PM, V1, Administrator, stated that she would expect her staff to perform trach care.</p> <p>The facility Equipment Change Schedule, dated 8/2023, documents 2. TRACHEOSTOMY: a) Replace disposable inner cannula daily (unless ordered otherwise) and prn. b) Trach tube is changed every three (3) months and prn (unless ordered otherwise) by a respiratory therapist/MD or a trained nurse. c) Clean permanent inner cannulas Q shift and prn. Provide trach care Q shift and prn with 50% Peroxide/Sterile saline solution. d) Tracheostomy: Dressing change Q shift and prn. e) Velcro trach collars and trach ties changed every 3 days and prn.</p>		