

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 10/15/2024
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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156</p> <p>Based on interview and record review the Facility failed to support the resident's right for the Power of Attorney (POA) to access their family's personal medical records and honor their written request for records for 1 of 3 residents (R2) reviewed for medical records in the sample of 6.</p> <p>Finding include:</p> <p>R2's Face sheet printed 9/19/2024 documents a diagnoses of sepsis, transient cerebral ischemic attack, type 2 diabetes, morbid obesity, difficulty in walking, unsteadiness on feet, cognitive communication deficit, weakness, anemia, Alzheimer disease, anxiety disorder, severe sepsis with septic shock. R2's Face sheet also documents she was admitted to the facility on [DATE].</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents (R2) is moderately impaired for cognition for decision making of activities of daily living.</p> <p>R2's Care Plan for ADL (activities of daily living) document she (R2) requires assist with daily care needs related to recent hospitalization for severe sepsis, weakness, and TIA (transient ischemic attack). Resident has a diagnosis of dementia and/or Alzheimer's and may display moods/behaviors related to diagnosis.</p> <p>R2's Progress Notes dated 1/10/2024 at 3:45 PM, documents, Transport here, resident transported to ER. (emergency room).</p> <p>R2's Progress Notes do not document anything related to the family and or resident requesting records.</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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/11/2024 at 10:45 AM, V5, family of R2 stated, We need (R2's) medical records and have been requesting them since February of 2024. (R2) was a patient back in January 2024. My husband is the POA (Power of Attorney), and he has filled out the privacy form several times. He has made several trips trying to get her records and we just recently met with the new Medical Records person (V9) and were trying to get her records. It has been one excuse after the other, first it was the weekend. We have met physically with multiple people, talked on the phone and still no records. Everything has been filled out multiple times. We have called and asked and have not received any records. The facility never talked to me about a fee for the records and have never asked or told us we had to pay. I don't have any issues with paying any reasonable amount fee for her records. We just want her medical records. I don't have any problem paying for her records, but nobody has ever told us how many papers it is or what it costs. We don't understand why we can't get her medical records and why we have to call the state to get her records. This is crazy and I am sorry I had to get you involved. You would think something like this could easily be done in two to three business days.</p> <p>On 10/11/2024 at 10:49 PM, V9, Medical Records, stated, I have only been here for three months. If someone wants records, they must fill out a form and then it goes to up to legal, they get back to me and let me know, once they have paid the fee then they get their records. (R2's) name sounds familiar I believe they just made a request not that long ago. I believe we already sent them her records. I will check and get back to you.</p> <p>On 10/11/2024 at 11:41 AM V6's Regional Health Information Medical Records phone number was provided.</p> <p>On 10/11/2024 at 11:43 AM, the phone number provided for V6 was a general number for the (Facility). A voice message was left.</p> <p>On 10/11/2024 at 1:32 PM, V9 stated she had a file on (R2) and gave it to (V4, AIT Administrator in Training) and was told she could not give me any other information.</p> <p>On 10/11/2024 at 4:00 PM, no proof of any medical records being sent to R2's family was provided by the facility.</p> <p>On 10/11/2024 at 4:03 PM, no Regional Medical Records staff member returned call or shared any information related to R2's medical records.</p> <p>On 10/11/2024 at 4:03 PM. The facility provided R2's medical records but there was no documentation in the records documenting any request of records had been shared with R2's family.</p> <p>The Resident Right Policy with a revision date of 11/2018 documents, Your facility must allow you to see your records within 24 hours of your request (excluding weekends and holidays). You may purchase a copy of part or all of your records at a reasonable copy fee within two working days of your request.</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35156</p> <p>Based on interview and record review the Facility failed to provide and document sufficient preparation and orientation for a safe and orderly discharge from the facility for 1 of 3 residents (R1) reviewed for discharge in the sample of 6.</p> <p>Findings include:</p> <p>R1's Physician Order Sheet (POS) for diagnoses of cerebral infarction due to embolism of left middle cerebral artery, type 2 diabetes mellites without complications, acute respiratory failure, unsteadiness on feet, lack of coordination, abnormal posture, chronic allergic conjunctivitis, bipolar, unspecified convulsion, acute kidney failure, acquired absence of right leg above knee, and depression. R1's POS documents he was taking levetiracetam oral tablets 750 milligrams two tablets twice a day related to epilepsy, oxcarbazepine tablet 600 mg., give 1 tablet by mouth two times a day (seizures), and spironolactone tablet 25 mg one time by mouth, one time a day (high blood pressure and heart failure).</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 was cognitively intact for decision making of activities of daily living. R1 requires a wheelchair, and he has impairment on his lower extremity,</p> <p>R1's Care Plan with a date initiated for 4/19/2023 documents, Discharge planning: The resident and guardian express the desire for the resident to continue long term. The resident's discharge potential and discharge planning needs have been assessed by the IDT (Interdisciplinary Team) and it has been decided to continue long term care. He would ultimately like to return home. Although he and family understand the need for long term care (LTC) placement. R1's Care Plan does not address or document any other discharge for R1.</p> <p>On 10/11/2024 at 1:23 PM, V23, Licensed Practical Nurse stated, All I remember is that (R1) had a planned discharge, and they said the aunt came and picked him up, but nobody knew about it and the aunt had to come back later and pick up his medication. (V4, Administrator in Training) was telling everyone (R1) was not supposed to be discharged until later but I guess there was a mix up and the family came before they were supposed to and there were some issues with his medications.</p> <p>On 10/11/2024 at 12:43 PM, V7, Family of R1 stated when they discharged (R1), they did not discharge him with all of his medication. I called the facility and left a message with (V2, Director of Nursing). (V2) called me back and they did not give me any scripts or any pills. I did not get any oral medication pills until three days later. It was a planned discharge and we had discussed it before, and I picked him up when they told me to pick him up. V7 started crying and saying (R1) was so neglected, and the facility attitude was they could care less. (R1) needs his medication and it is not like I can just go to the grocery store and get it. They acted like I was bothering them when I was just trying to get his medication to make sure he had everything he needed.</p> <p>(continued on next page)</p>		

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<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Progress Notes dated 10/6/2024 at 7:38 PM, Patient discharged from facility today around 2:30 PM with his aunt. I attempted to go over medication with resident and aunt, but resident was busy on his phone. I sent all medications with him. Aunt and another family member took all belongings with them. Apparently, he will be living on the property of his aunt's home on his own and be responsible for his own medication administration along with his insulin. R1's Progress Notes do not document any medication was sent with R1.</p> <p>The Resident discharge Policy-Not Hospital Policy with a revision date of 1/2024 documents, To provide direction other than the hospital. Complete nursing section of Discharge Instructions for in PCC (electronic computer program) this form is opened by Social Service and completed by nursing prior to discharge. Once completed, instructions should be printed along with a medication list and reviewed with the resident/resident representative. After review, the resident/representative should sign the discharge instructions sheet, a copy should be given to them and the original scanned into the medical record. All appropriate medications should be given to the resident at the time of discharge per physician order. Do not complete the discharge without receiving the order from the Medical Doctor/NP (Nurse Practitioner).</p>		