

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 11/14/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 thoroughly investigate and report allegations of sexual abuse for 1 of 3 residents (R2) reviewed for sexual abuse in the sample of 11.</p> <p>Findings include:</p> <p>R2's Care Plan, dated 10/23/24, documents ABUSE: At risk for abuse and neglect r/t (related to). It continues Assess resident for abuse and neglect upon admission and quarterly. Assure the resident that staff members are available to help, and department heads maintain an open door policy. Continue to in-service the staff about abuse and neglect. Continue to monitor medication, ADLs, status and behaviors. Observe the resident for signs of fear and insecurity during delivery of care. Take steps to calm the resident and help him/her feel safe.</p> <p>R2's Minimum Data Set, dated [DATE], documents that R2 is cognitively intact.</p> <p>R2's Progress Note, dated 10/13/2024 at 4:02 PM, documents Nurses Notes Late Entry: Note Text: Resident came to nursing station with another female resident. second female resident looked at this resident and stated, Tell her what he did. Then this resident stated a male resident touched her inappropriately while they were standing in the hallway waiting to go out for a smoke break. This nurse went with this resident to the hallway so resident can show this nurse which male resident touched here. Male resident removed from hallway and separated from this resident. Male resident took back to male side of the building and this nurse notified his nurse of incident. second nurse stated she would notify MD (medical doctor) and Admin (administrator) of incident.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Progress Note, 10/22/2024 at 8:02 PM, documents Nurses Notes Note Text: At approximately 4:40pm, Resident (R5), came to the nurses desk, and reported to 100 hall nurse (who was sitting at first computer at nurses desk by 200 hall) and myself, (who was sitting at the second computer at the desk by the far wall from 200 hall) that (V2, Director of Nurses) was saying that another resident has been touching her vagina. I notified (V5) the wound nurse/management, of this. She stated to separate (V2) from the resident that (V2) stated was doing this. And put the resident touching her, on one-on-one supervision. She also said for this nurse to get statements from any witnesses. I obtained a statement from Resident, (R5), that resident, (R6), was present at the time the accused resident was touching (R2) inappropriately. I then asked (R2) what happened and if anyone, but the accused resident was present when he was touching her. She also named (R6) and stated that he witnessed it. I then asked (R6) if he was present at the time of the incident and he stated that the resident in question was (R3) and that he was present when (R3) was touching (R2) and that he himself told (R3) he needed to stop and not to do that ever again. (R3) was outside coming inside from smoke break. I questioned (R3) with reality orientation questions to establish his alertness level. Such as what is your first and last name, where are you, etc. (R3) stated his first and last name and responded, do you think I am stupid? I went to college, and I have a degree he proceeded to tell me where he was and where he went to college and where he got a degree from. I asked him if he knew what was going on at the moment. He replied, I don't know. I asked him do you know what's going on with her. ((R3) was not present. I did not say her name.) (R3) responded We're consenting adults. I told (R3) she is saying she isn't consenting. (R3) did not say anything further and did not talk any further with this nurse.</p> <p>On 10/31/2024 at 9:44 AM, R2 stated that she was inside the building standing in line for the smoke break. R2 stated that (R3) grab her vagina with his hand. R2 stated that she yelled stop. R2 stated that it was not her leg it was her vagina. R2 stated that she has a past history of sexual abuse and that this triggered her. R2 stated that (R7) was there, and (R7) went with her to report it.</p> <p>On 10/31/2024 at 9:47 AM, R7 stated that she was standing in line between (R3) and (R2). R7 stated that out the corner of her eye she saw (R3) reach out towards (R2) and hand went across her legs. R7 stated that she did not see (R3) grab (R2's) vagina. R7 stated that she heard (R2) say stop. R7 stated that (R2) informed R7 of what happened and R7 took her to the nurse.</p> <p>On 10/13/2024 at 10:14 AM, R3 stated that he likes (R2) and finds her attractive. R3 stated that they talk. R3 stated that he has not touched (R2). R3 stated that he does not remember grabbing (R2).</p> <p>R3's Care Plan, dated 10/21/24, documents that the resident displays behavioral Symptoms related social interaction which is manifested by touching others to get their attention. Resident is at wheelchair height and reaches out to get to where he is going. It also documents Intervene when any inappropriate behavior is observed. Attempt to educate and redirect. Provide supportive group. 1:1 PRN intervention. Refer the resident to the consulting psychiatrist for a psychiatry evaluation, as warranted.</p> <p>R3's MDS, dated [DATE], documents that R3 is cognitively intact.</p> <p>R3's Medical Diagnosis list Mild Cognitive Impairment of Uncertain or Unknown Etiology, Schizoaffective Disorder, Unspecified, Alcohol Dependence, Uncomplicated.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/31/2024 at approximately 1:00 PM, V9, Regional Director of Operations, stated that they were made aware of the incident that occurred on 10/22/24. V9 stated that (V2), Director of Nursing, and (V5), Wound Nurse, came up to facility. V9 stated that they were notified that (V6), Staffing Coordinator, was outside on smoke break and that no event occurred out there. V9 stated that no further investigation was done and it was not reported to outside agency because they did not believe it was necessary because (V6) did not witness anything outside. V9 stated that in the days following they were made aware of the incident that occurred on 10/13/2024. V9 stated that this was not reported or investigated. V9 verified that the facility has cameras and that they had not viewed the [NAME] footage.</p> <p>The facility's Abuse Policy, dated 10/2022, documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. VII. Internal Investigation 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation. External Reporting 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has been made, the administrator, or designee shall notify Department of Public Health's regional office immediately by telephone or fax. 2. Five-day Final Investigation report. Within five working days after the report of occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</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 initiate its Abuse Prevention policy for 1 (R2) of 3 three residents reviewed for sexual abuse in the sample of 11.</p> <p>Findings include:</p> <p>On 10/31/2024 at approximately 1:00 PM V9, Regional Director of Operations, stated that they were made aware of the incident that occurred on 10/22/24. V9 stated that (V2), Director of Nursing, and (V5), Wound Nurse, came up to facility. V9 stated that they were notified that (V6), Staffing Coordinator, was outside on smoke break and that no event occurred out there. V9 stated that no further investigation was done and it was not reported to outside agency because they did not believe it was necessary because (V6) did not witness anything outside. V9 stated that in the days following they were made aware of the incident that occurred on 10/13/2024. V9 stated that this was not reported or investigated. V9 verified that the facility has cameras and that they had not viewed the [NAME] footage.</p> <p>On 10/31/2024 at approximately 1:03 PM, V2, Administrator, stated that the incidents from 10/13 and 10/22 were not reported to outside agency.</p> <p>The facility's Abuse Policy, dated 10/2022, documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. VII. Internal Investigation 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property will result in an investigation. External Reporting 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has been made, the administrator, or designee shall notify Department of Public Health's regional office immediately by telephone or fax. 2. Five-day Final Investigation report. Within five working days after the report of occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112</p> <p>Based on interview, observation, and record review, the facility failed to measure, assess, monitor, and treat wounds when identified and obtain orders to treat wounds for 1 of 1 (R4) reviewed for wounds in the sample of 11.</p> <p>Findings include:</p> <p>R4's Admission Record, print date of 11/4/24, documents that R4 was admitted on [DATE] with diagnoses of Osteomyelitis, Diabetes Mellitus.</p> <p>R4's Minimum Data Set, dated dated [DATE], documents that R4 is cognitively intact.</p> <p>R4's Admission Note, dated 10/8/2024 22:30, documents, 18) Left elbow left elbow infection osteomyelitis.</p> <p>R4's Nurses Note, dated 10/8/2024 22:24, documents, The patient arrived to facility via EMS (Emergency Medical Services). Patient alert and oriented times 3. Patient oriented to room, call light within reach, Left elbow infection/wound noted.</p> <p>R4's Nurses Note, dated 10/9/2024 12:55, created date of 10/16/2024 15:58:26, documents, Late Entry: Resident admitted to (facility) on IV (intravenous) antibiotics due to osteomyelitis, resident admitted with a venous wound relate to a wound from the inside out. Wound will be treated daily with a hydro mix with collagen and Silvadene cream daily. Will monitor daily.</p> <p>R4's Physician Orders, dated 10/16/24 documents, Cleanse wound on left elbow with wound cleanser, apply santyl and cover with a 4x4 bordered gauze daily and prn (as needed) until healed. Monitoring for s/s (signs and symptoms) of infection, notify MD (Medical Director).</p> <p>R4's Physician Orders, dated 10/23/24, documents, cleanse wound on right second toe with wound cleanser, mix hydrogel, collagen, and Silvadene cream and cover with a dry dressing daily and prn until healed. Monitoring for signs and symptoms of infection, notify MD.</p> <p>R4's Treatment Administration Record, dated 10/2024, fails to document any treatment for R4's left elbow before 10/17/24.</p> <p>R4's Treatment Administration Record, dated 10/2024, fails to document any treatment for R4's right second toe before 10/23/24.</p> <p>R4's Skin and Wound Note, dated 10/11/2024 05:49, documents, Date of Service: 10/11/2024 10:49 AM Evaluation of her skin today reveals no open wounds, sores, or lesions; skin is intact.</p> <p>R4's Skin & Wound Evaluation, dated 10/16/2024 3:32 PM, documents, Midline infiltration caused from the inside. Location left elbow present on admission. Area 4.6 cm (centimeters) 2 2. Length 2.2 cm 3. Width 2.7 cm. There is no other documentation regarding the wound on this Skin & Wound Evaluation. This is the first documentation of R4's left elbow measurements.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R4's Skin and Wound Note, dated 10/18/2024 05:30, documents, Date of Service: 10/18/2024 10:30 AM WOUND ASSESSMENT: Wound: 1 Location: left elbow Primary Etiology: Abscess Stage/Severity: Full Thickness Wound Status: Present on Admission Odor Post Cleansing: Mild Size: 3.1 cm x 2 cm x 0 cm. Calculated area is 6.2 sq cm. Wound Base: , 100% eschar Wound Edges: Attached Periwound: Intact Exudate: Moderate amount of Sanguineous.</p> <p>Wound: 2 Location: right second toe Primary Etiology: Diabetic Foot Ulcer (DFU) Stage/Severity: Full Thickness Wound Status: New Odor Post Cleansing: None Size: 0.9 cm x 0.8 cm x 0.1 cm. Calculated area is 0.72 sq cm. Wound Base, 100% granulation Wound Edges: Attached Periwound: Intact, Callous Exposed Tissues: Epithelium, Dermis Exudate: Scant amount of Serous. This is the first full documentation for R4's left elbow and right second toe.</p> <p>On 11/4/24 at 9:45 AM, V5, Licensed Practical Nurse, LPN, stated that R4 should have wound measurements and treatments documented because she thought she did them.</p> <p>On 11/12/24 at 11:55 AM, V2, Director of Nurses, stated that wounds should be measured and described when found, then weekly, or if they get worse. The doctor should be notified of the wound and orders for treatment should be obtained.</p> <p>On 11/13/24 at 10:14 AM, V5, Wound Nurse Licensed Practical Nurse (LPN), stated, If a resident is admitted or readmitted to the facility, the nurse will do a skin assessment, but I don't know if they measure the wounds are not. I will have to look into that. V5 agreed that there is no full beginning assessment of the wounds or pressure ulcers if one is not completed upon admission, readmission, or when found.</p> <p>The policy Skin and Wound Management Guidelines, undated, documents, Admission or Readmission. Staff Nurse. 1. Complete the Comprehensive Nursing Assessment including the skin with thorough and descriptive documentation of any alteration in skin integrity. 2. Complete the Braden Assessment 2. Complete the Braden Assessment 3. If there is a wound present on admission: Ensure there is a treatment order. Ensure specialty mattress is in place if needed. Ensure cushion is provided for wheelchair if needed. Wound Care Nurse: 1. Review new admissions and readmissions and assess, measure, photograph, and document in Wound Rounds on any wound identified. This includes Stage I's and significant skin tears. It continues, Ensure the treatment order is in place and appropriate. New Facility Acquired Wounds: Staff Nurse. 1. Notify wound care nurse of new alteration in skin integrity. If the wound care nurse is not in the facility, then you must notify the physician and obtain treatment order. It continues, 1. Assess, measure, photograph, and document in Wound Rounds. 2. Complete the Braden Assessment. 3. Obtain or ensure appropriate treatment order is in place. This policy fails to document ongoing wound or pressure ulcer assessment.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112</p> <p>Based on interview, observation, and record review, the facility failed to assess and monitor pressure ulcers, provide Physician prescribed treatment, and maintain clean dressings for 2 of 3 residents (R1, R11) reviewed for pressure ulcers in the sample of 11.</p> <p>Findings include:</p> <p>1. On 10/31/24 at 3:00 PM, R1 is lying in bed. R1 has no dressing on his left heel. R1's right heel protector boot is positioned on the middle of his calf. R1's right heel dressing is at his ankle and his mid foot. R1's dressing is red, tan and brown in color with drainage. R1's sheet has fresh and old blood stain in multiple areas at the bottom half of the right side of the sheet.</p> <p>On 10/31/24 at 3:00 PM, R1 stated that his heel has been bleeding all night. R1 stated that it has been a problem for the last 3 or 4 days. R1 stated that his right heel dressing was last changed yesterday or the day before. R1 stated that his left heel never has a dressing on it.</p> <p>On 10/31/24 at 3:10 PM, V3, Assistant Director of Nurses, entered R1's room to do dressing changes to R1's heels. V3 raised R1 left heel and cleansed it with wound cleanser, applied betadine-soaked gauze, and wrapped with a border foam dressing. The pressure ulcer was 5 centimeters (cm) x 4 cm. The middle of the pressure ulcer was dark brown. The outer area of the pressure ulcer was light red.</p> <p>On 10/31/24 at 3:53 PM, V3, attempted to remove the old dressing from R1's right foot. The dressing was dry and stuck on R1's skin at the heel. V3 saturated the gauze with wound cleanser to loosen the dressing. The abdomen (abd) pad was saturated with brown drainage and dried blood. The pressure ulcer was from the back of his heel to just below his midfoot approximately 9 cm in length. The pressure ulcer extended the width of his foot. The pressure ulcer was also at the back of his heel extending from the sole of his foot up approximately 4 cm. This area was actively bleeding. V3 cleansed the pressure ulcer with wound cleanser, applied a hydrogel, silvadene, and collagen mixture, then Santyl, placed an abd pad, and then wrapped the right foot in gauze.</p> <p>On 11/4/24 at 9:41 AM, V3, stated R1's old right foot dressing on 10/31/24 was not in good condition and it should have been addressed sooner. I don't know how old that was, but it was stuck on there. There was suppose to be no Santyl put on the right heel. The order wasn't updated.</p> <p>R1's Admission Record, print date of 11/4/24, documents that R1 was admitted on [DATE] and has diagnoses of Type 2 Diabetes Mellitus, End Stage Renal Disease, dependency on Renal Dialysis, and Osteomyelitis acquired 10/15/24.</p> <p>R1's Minimum Data Set, dated dated [DATE], documents that R1 is cognitively intact and dependent on staff for all mobility.</p> <p>R1's Braden Scale for predicting Pressure Ulcer Sore Risk evaluations, dated 7/11/24 - 10/14/24, all document that R1 is at risk for developing pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Skin & Wound Evaluation, dated 8/26/24, documents, WOUND ASSESSMENT: Wound: 1 Location: Right heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Improving despite measurements Odor Post Cleansing: None Size: 5 cm x 5.5 cm x 0.5 cm. Calculated area is 27.5 sq (square) cm. Wound Base: , 30% granulation , 70% slough Exposed Tissues: Subcutaneous, Adipose Wound Edges: Attached Peri wound: Fragile, Macerated Exudate: Heavy amount of Serosanguineous Wound Pain at Rest: 0.</p> <p>R1's Skin & Wound Evaluation, dated 9/4/24, documents, Patient was unable to be evaluated by the skin and wound team today; patient was not in facility at the time of visit. Hospital.</p> <p>R1's Skin & Wound Evaluation, dated 9/13/24, documents, Patient was unable to be evaluated by the skin and wound team today; patient at dialysis during time of visit.</p> <p>R1's Electronic Medical Record fails to document R1's right heel pressure ulcer between 8/26/24 and 9/16/24.</p> <p>R1's Skin & Wound Evaluation, dated 9/16/24, documents, WOUND ASSESSMENT: Wound: 1 Location: Right heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Stalled Odor Post Cleansing: Malodorous Size: 5 cm x 6 cm x 0.5 cm. Calculated area is 30 sq cm. Wound Base: , 10% granulation , 90% slough Exposed Tissues: Epithelium, Dermis, Subcutaneous, Adipose Wound Edges: Attached Peri wound: Fragile, Macerated Exudate: Heavy amount of Serosanguineous Wound Pain at Rest: Insensate (lacks sensation).</p> <p>R1's Electronic Medical Record fails to document R1's right heel pressure ulcer between 9/16/24 and 9/27/24.</p> <p>R1's Skin & Wound Evaluation, dated 9/27/24, documents, WOUND ASSESSMENT: Wound: 1 Location: Right heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Stable Odor Post Cleansing: Malodorous Size: 5 cm x 6.7 cm x 0.5 cm. Calculated area is 33.5 sq cm. Wound Base: , 80% granulation , 20% slough Exposed Tissues: Epithelium, Dermis, Subcutaneous, Adipose</p> <p>Wound Edges: Attached Peri wound: Fragile, Macerated Exudate: Heavy amount of Serosanguineous Wound Pain at Rest: Insensate.</p> <p>R1's Skin & Wound Note, dated 10/2/2024 09:39, documents, WOUND ASSESSMENT: Wound: 1 Location: Right heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Stable Odor Post Cleansing: Malodorous Size: 9 cm x 10 cm x 0.5 cm. Calculated area is 90 sq cm. Wound Base: , 80% granulation , 20% slough Exposed Tissues: Epithelium, Dermis, Subcutaneous, Adipose Wound Edges: Attached Peri wound: Fragile, Macerated Exudate: Heavy amount of Serosanguineous Wound Pain at Rest: Insensate.</p> <p>R1's Wound Care Note, dated 10/7/2024 10:47, documents, Resident sent to hospital, treatment not done, resident admitted , will continue treatments upon readmission to building.</p> <p>R1's Nurses Note, dated 10/14/2024 18:37, documents, Resident; black 70 y.o. (year old) black male; returned from (Hospital) and was transported to this facility via (Ambulance) at 6:25 pm. It continues, New discharge order for ABT (antibiotic) for PNE (pneumonia)and Osteomyelitis to R (right) heel. Resident has right foot debridement and right heel bone biopsy 10/11.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Hospital Discharge Summary, dated 10/14/24, documents that R1 has bilateral heel pressure ulcers.</p> <p>R1's Daily Skilled Nurses Note, dated 10/18/24, documents that R1 has a pressure ulcer on both the right and left heels. This Nurses Note fails to document size or assess the pressure ulcers. R1's Electronic Medical Record fails to document R1's left heel pressure ulcer before 10/18/24.</p> <p>R1's Treatment Administration Record, dated 10/24, documents, Cleanse left heel with wound cleanser, dab with betadine soaked gauze, cover with bordered gauze daily and PRN (as needed) until healed. Start date of 10/17/24.</p> <p>R1's Skin & Wound Note, dated 10/22/2024 , documents, Location: Right heel Primary Etiology: Pressure Stage/Severity: Stage 3 Wound Status: Stable Odor Post Cleansing: Malodorous Size: 8.5 cm x 8 cm x 0.5 cm. Calculated area is 68 sq cm. Wound Base: , 80% granulation , 20% slough Exposed Tissues: Epithelium, Dermis, Subcutaneous, Adipose Wound Edges: Attached Periwound: Fragile, Macerated Exudate: Heavy amount of Serosanguineous Wound Pain at Rest: Insensate. Wound: 4 Location: left heel Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Present on Admission Odor Post Cleansing: None Size: 6 cm x 7 cm x 0 cm. Calculated area is 42 sq cm. Wound Base, 100% eschar Wound Edges: Attached Periwound: Fragile. This is the first full assessment of R1's bilateral pressure ulcers since readmission on 10/14/24.</p> <p>R1's Skin & Wound Note, dated 10/30/2024, documents, Patient was unable to be evaluated by the skin and wound team today; patient at dialysis during time of visit.</p> <p>R1's Skin & Wound Note, dated 11/6/2024 12:24, documents, WOUND ASSESSMENT: Wound: 1 Location: Right heel Primary Etiology: Pressure Stage/Severity: Stage 4 Wound Status: Stable Odor Post Cleansing: None Size: 8 cm x 8 cm x 2 cm. Calculated area is 64 sq cm. Wound Base: , 100% granulation , 0% slough Exposed Tissues: Epithelium, Dermis, Subcutaneous, Adipose, Muscle/Fascia Wound Edges: Attached Periwound: Intact, Fragile Exudate: Heavy amount of Seropurulent Wound Pain at Rest: 2 Wound: 4 Location: left heel Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Present on Admission Odor Post Cleansing: None Size: 4.5 cm x 6.5 cm x 0.1 cm. Calculated area is 29.25 sq cm. Wound Base: , 20% granulation , 80% slough , 0% eschar Wound Edges: Attached Periwound: Fragile, Intact Exudate: Moderate amount of Serous Wound Pain at Rest: 0.</p> <p>On 11/13/24 at 10:14 AM, V5, Wound Nurse Licensed Practical Nurse (LPN), stated, I do rounds with the Wound Nurse Practitioner every week. If a resident is not able to be seen by the Wound Nurse Practitioner I do still measure their wounds and document on them. If a resident is admitted or readmitted to the facility, the nurse will do a skin assessment, but I don't know if they measure the wounds are not. I will have to look into that. V5 agreed that there is no full beginning assessment of the wounds or pressure ulcers if one is not completed upon admission, readmission or upon finding. V5 was unable to state why (R1) did not have weekly pressure ulcer assessments or readmission pressure ulcer assessments.</p> <p>(continued on next page)</p>		

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 11/14/2024
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.			
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/13/24 at 2:19 PM, V18, Nurse Practitioner, stated that (R1) has many disease processes: Dialysis, Diabetes, Peripheral Vascular Disease, and Osteomyelitis. V18 stated that with his health his pressure ulcers are very difficult to heal. They would be hard to heal in a healthy person but for him it is really difficult. V18 stated, I am not sure why they haven't amputated that right foot yet. When I saw him today, he had his heel protector up on his leg too. He does that himself. V18 felt that his pressure ulcers not being measured every week really did not cause him any harm.</p> <p>On 11/12/24 at 11:55 AM, V2, Director of Nurses stated that wounds and pressure ulcers should be measured and described when found, then weekly, or if they get worse. The doctor should be notified of the wound and orders for treatment should be obtained.</p> <p>2. R11's Admission Profile, print date of 11/14/24, documents that R11 was admitted on [DATE] and has diagnoses of Chronic Respiratory Failure and a Pressure Ulcer to the Sacrum Stage 4.</p> <p>R11's MDS, dated [DATE], documents he is cognitively intact.</p> <p>R11's Physician Order, dated 9/7/24, documents, cleanse wound on sacrum with wound cleanser, apply medihoney and collagen and cover with bordered gauze daily and prn until healed. Monitor for s/s of infection and, notify MD.</p> <p>On 11/13/24 at 9:34 AM, V5 prepared the pressure ulcer dressing for (R11's) coccyx. She placed a mixture of hydrogel, collagen, and silvadene onto a calcium alginate square then placed that on top of a bordered dressing. V5 entered R11's room, cleansed the pressure ulcer with wound cleanser and then applied the dressing. The pressure ulcer was 2 cm in length and 0.5 cm in width. The center of the pressure ulcer was dark red.</p> <p>On 11/13/24 at 9:58 AM, V5 was questioned why her treatment of (R11's) pressure ulcer did not match what was on his Physician Orders of medihoney and collagen, V5 stated, No he is suppose to get the hydrogel, collagen, and silvadene mixture. V5 reviewed (R11's) Physician Orders, V5 stated, I took the order from the wound Nurse Practitioners Wound Assessment. I must have written the wrong order into the system. V5 further stated, When the wound Nurse Practitioner writes orders on the Wound Assessment Report, I go back and enter the order into the system which will transfer it to the Physician Orders in the PCC (Point Click Care) (computer) system and populate onto the TAR (Treatment Administration Record). V5 agreed that if she was not the nurse that did the pressure ulcer dressing change (R11's) pressure ulcer would have been treated with the wrong treatment.</p> <p>On 11/13/24 at 2:19 PM, V18, Wound Nurse Practitioner, stated that (R11) receiving the wrong pressure ulcer treatment of medihoney and collagen did not harm him.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The policy Skin and Wound Management Guidelines, undated, documents, Admission or Readmission. Staff Nurse. 1. Complete the Comprehensive Nursing Assessment including the skin with thorough and descriptive documentation of any alteration in skin integrity. 2. Complete the Braden Assessment 2. Complete the Braden Assessment 3. If there is a wound present on admission: Ensure there is a treatment order. Ensure specialty mattress is in place if needed. Ensure cushion is provided for wheelchair if needed. Wound Care Nurse: 1. Review new admissions and readmissions and assess, measure, photograph, and document in Wound Rounds on any wound identified. This includes Stage I's and significant skin tears. It continues, Ensure the treatment order is in place and appropriate. New Facility Acquired Wounds: Staff Nurse. 1. Notify wound care nurse of new alteration in skin integrity. If the wound care nurse is not in the facility, then you must notify the physician and obtain treatment order. It continues, 1. Assess, measure, photograph, and document in Wound Rounds. 2. Complete the Braden Assessment. 3. Obtain or ensure appropriate treatment order is in place. This policy fails to document ongoing wound or pressure ulcer assessment.</p>		

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NAME OF PROVIDER OR SUPPLIER Bria of Alton		STREET ADDRESS, CITY, STATE, ZIP CODE 3523 Wickenhauser Alton, IL 62002	
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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112</p> <p>Based on interview, observation, and record review, the facility failed to replace a loose dressing for 1 of 2 residents (R4) reviewed for Peripherally Inserted Central Catheter (PICC) lines in the sample of 11.</p> <p>Findings include:</p> <p>On 10/31/24 at 12:13 PM, V3, Assistant Director of Nurses / Registered Nurse (RN) entered R4's room. V3 disconnected the Intravenous (IV) antibiotic from R4's left upper arm Peripherally Inserted Central Catheter (PICC) line, flushed the line with 5 milliliters of normal saline, and capped the lumen. The PICC line dressing was not attached at the bottom of the dressing. V3 washed her hands and left the room.</p> <p>On 10/31/24 at 4:16 PM, V3 stated that she was aware that (R4's) PICC line dressing was not attached at the bottom. I told the night RN that just came in about it so she would change it.</p> <p>R4's Admission Record, print date of 11/4/24, documents that R4 was admitted on [DATE] with diagnoses of Osteomyelitis and Diabetes Mellitus.</p> <p>R4's Physician Orders, dated 10/28/2024, documents, Change PICC line dressing weekly and prn (as needed) using sterile technique.</p> <p>On 11/12/24 at 12:00, V2, Director of Nurses, stated that if a RN notices a PICC line dressing that is not secure they should stop and change it.</p> <p>The policy Central Venous Catheter Maintenance, dated 8/24/24, documents, 5. Proper procedure will be used for catheter site dressing monitoring/changes. Apply clear dressings every 7 days or more frequently if soiled, damp, or loose.</p>		