STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005474	A. BUILDING: _____ B. WING _____	C 06/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF BELLEVILLE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2144307/IL135141	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210b)4) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on interview and record review the facility failed to answer call lights in a timely manner to promote residents' dignity for 5 of 5 residents (R1-R5) reviewed for dignity in the sample of 5. This failure resulted in R2 experiencing extreme anxiety and fear that she would not receive assistance; causing her to sign out of the facility against medical advice and R5 experiencing extreme anxiety and fear that she would not receive assistance if she became choked or, had a heart attack. Findings include: 1.R2's Minimum Data Set, (MDS), dated 4/8/2021 documents diagnoses' of Medically Complex Conditions, Coronary Artery Disease; Diabetes	S9999		

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S9999	Continued From page 2 Mellitus; Hypertrophied; Cerebrovascular Accident; Malnutrition. R2's MDS documents she is cognitively intact. R2's MDS documents that she has ability to independently toilet. R2's Progress Notes dated 4/7/2021 at 6:02 PM document, "Resident arrived via ambulance with 2 emts (emergency medical technicians) from (local hospital). resident a&o (alert and oriented) x 3 calm and cooperative. Resident 1 assist with walker resident denies pain or discomfort call light in reach will cont (continue) to monitor." R2's Progress Notes dated 4/7/2021 at 10:32 PM document, "Res (Resident) call her son that she wasn't change for an hour and call btn (button) taken away from her. Son came, wanted to see her and threaten he will call State. The writer and another nurse talked to son assured him will take care of it. DON was involved too. Res changed to (another room), maintenance reset call btns (buttons) on hall 100. Writer left voice message for son to notify him of room change. Will continue to monitor and check on her q2h (every two hours)." There was no documentation in R2's medical records that R2 was checked every two hours. R2's Progress Notes dated 4/8/2021 at 3:04 PM document, "resident left AMA (Against Medical Advice) with granddaughter." On 6/22/2021 at 3:40 PM, R2 stated that she was placed in a diaper and that she did not need to be put in a diaper that she could use a bedside commode. She also stated that when she put her call light on, they would not answer it and told her that she was not the only resident in the building to quit putting her call light on.	S9999		

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S9999	Continued From page 3 R2 stated on 6/25/2021 at 10:00 AM, "I was so upset and humiliated that they let me lay in a diaper when I didn't need one. It upset me so much that I called my son to come and get me. I was very afraid of the way they were treating me there. It was if I wasn't even human." R2 confirmed this was the reason why she left against medical advice. On 6/25/2021 at 2:31 PM, V1 Administrator, stated that the call lights at nurse's station on 100-200 halls can be turned off manually but not on 300-400 hall. V1 also stated that R2 was placed on the 100 hall but when the call light wasn't working R2 was moved to a special unit on the two hundred call. 2. R5's Electronic Medical Records documents R5 has diagnoses of Acute on Chronic systolic (Congestive heart failure), Morbid (Severe)) obesity due to excessive calories, COPD, Unspecified Type 2 Diabetes Mellitus without Complications, Cerebral infarction due to unspecified occlusion or stenosis of unspecified Cerebral artery, Anemia in chronic kidney disease, Diverticulitis of both small and large intestine without perforation or abscess without bleeding. On 6/25/2021 the facility provided the facility provided a grievance report that R5 had filed for call lights not being answered. The facility grievance form dated 6/3/2021 documents that R5 filed a grievance on call lights and it was not witnessed but the second time this issue had been reported. On 6/25/2021 at 1:02 PM R5 stated, "No it hasn't stopped. They turn the call lights off at the nurse's	S9999		

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S9999	Continued From page 4 station. Sometimes I am up until 8 PM in this chair and I put my call light on, and they don't answer. I could be having a heart attack, choking or anything else and they wouldn't come. I am afraid and it makes me feel horrible." 3. On 6/25/2021 at 11:45 AM R3 stated "The regular ones are good but sometimes they have people work that are very poor with answering the lights and they just don't answer them at night." 4. On 6/25/2021 at 12:06 PM R1 stated "They turn my light off when I put it on and do not answer it." 5. On 6/25/2021 at 1:19 PM R4 stated "Most of the time they answer my lights but many times at night they turn it off and won't answer it." The facility's Call Light Policy dated 9/2017 documents in part, "6. Report all defective call lights to nurse supervisor or maintenance director promptly. 7. Answer the patient or residents call as soon as possible." (B)	S9999		