STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003768	A. BUILDING: _____ B. WING _____	10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF MASCOUTAH	901 NORTH TENTH STREET MASCOUTAH, IL 62258

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S 000	Initial Comments Annual Certification Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Findings 300.610a) 300.121b) 300.1210d)6 300.3240a) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to prevent abuse for 4 of 5 residents (R4, R13, R38, R102) reviewed for abuse in the sample of 43. This failure resulted R102 who is demented being fondled by R38 in the dining room and a reasonable person would not want to be sexually fondled/abused. Findings include: 1.R38's Face Sheet, with print date of 10/192/3, documents R38 has diagnoses of personal history of traumatic brain injury, major depressive disorder, schizoaffective disorder, bipolar type, and altered mental status. R38's Care Plan, dated 9/11/23, documents	S9999		

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S9999	Continued From page 2	S9999		

"Resident's memory is impaired, and resident has difficulty with decision-making, insight, logic, planning, and organization of the thoughts." The Care Plan Interventions documented "Provide clear explanations regarding expectations and procedures prior to providing care." R38's Care Plan documents "Resident has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior, but has demonstrated stability during the admission screening process and is therefore considered appropriate for admission. The history includes: kicking at other residents and their wheelchairs, and aggressively grabbing at staff." The Interventions documents "Intervene when any inappropriate behavior is observed. Communicate assertively that the resident must exercise control over impulses and behaviors (Social skills training)."

R38's Minimum Data Set, MDS, dated 9/30/23 documents R38 is moderately cognitively impaired.

R102's Face Sheet, undated, documents R102 has diagnosis of Unspecified Dementia without behavioral disturbance.

R102's MDS dated 9/22/23 documents R102 is severely cognitively impaired.

R38's Nurse's Note dated 10/17/23 at 6:15 PM documented "CNA (Certified Nursing Assistant) came to this nurse with report that this resident (R38) had potentially abused another resident (R102). Administrator notified at 6:16 PM. Resident is being monitored on one on one per staff."

R102's Nurse's Note dated 10/17/23 documents

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S9999	Continued From page 3 "CNA brought resident to this nurse with report of potential abuse from another resident @ 615pm. Resident questioned and denied pain. Resident stated when asked what happened " that's about how it goes". Administrator notified at 6:16pm. Skin assessment completed with no new skin issues found. Son notified and MD notified. Facility Reported Incident, dated 10/17/23, documents "This resident was found with alleged perpetrator standing over her with his hands on her brief." The Report documented the Police, Medical Director and Power of Attorney were contacted and notified. V24, Certified Nurse's Assistant, CNA, statement, dated 10/17/23 at 6:28 PM documents "At approx. (approximately) 6:15 PM I walked in the dining room and witness (R38) standing over (R102). When I walked up closer, I witnessed one of (R38's) hands two knuckles down in (R102's) (incontinent brief), and the other hand on her (R102) strap of her (incontinence brief). I immediately remove his (R38's) hands and remove (R102) from the dining room and took her with me for safety. I reported what I saw to the nurse. On 10/19/23 At 12:44 PM V24 stated, "I was walking a couple of residents to go smoke I saw (R38) standing over (R102). I saw his hands down her pants I took her to the nurse and reported what I seen." V27's, Dietary Aide, statement dated 10/17/23 documents "I (V27) had just told (R38) that he cannot help (R102) with incontinence brief and that a nurse or a CNA will have to help (R102) with her incontinence brief, and that was around 5:45 PM 6:00PM last night."	S9999		

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S9999	Continued From page 4 On 10/19/23 at 12:48 PM V27 stated, "I prepared the residents dialysis breakfast and took it to the nurses the station. When I returned, I saw (R38) standing close to her (R102), and her incontinent brief was unfastened. I told him to go sit down." V23's, Licensed Practical Nurse (LPN) Witness Statement dated 8/17/23 documents "I asked (R38) why he was touching (R102's) (incontinence brief) and he smiled at me and stated you have no proof. On 10/19/23 at 1:5 PM, V23 stated "At 6:15 PM a CNA brought (R102) to me and said that (R38) had his hand down inside of her incontinence brief and looked like her vaginal area. When she brought (R102) to me the right side of her (incontinent brief) was unfastened and the front of her pants were pulled down. I did skin assessment, and no skin issues were found. She denied pain. I asked (R38) if he had touched (R102), and he stated, 'you have no proof.' I made him a one to one." V25's Witness Statement, dated 10/17/23 documents "At about 6:15 PM me and (V24) was walking through the dining area to take the residents out for a smoke break. Upon entering the dining area, I saw (R38) standing over (R102) holding her underwear. Her shirt was midway up her stomach. (V24) immediately removed (R102) and took her (R102) to the nurse to report. I asked (R38) what was he doing with her (R102), and he (R38) stated nothing. I asked him (R38) what was nothing, and why was he tugging on her (R102) underwear and he didn't respond. On 10/19/23 at 1:22 PM V19 LPN stated, "He (R38) has grabbed my butt He (R38) tries to flip	S9999		

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S9999	Continued From page 5 other residents out of the wheelchair." On 10/19/22 23 at 1:24 PM V30, CNA stated, "He (R38) says weird stuff he (R38) tries to push people wheelchair. He is very aggressive. He (R38) tries to elope." On 10/19/23 at 1:32 PM V32, CNA stated, "He (R38) has inappropriate behaviors all the time. He (R38) pulls his penis out of his pants and pees on the floor. He grabbed butts and he took (R21's) drink and tried to give it to her." On 10/19/23 at 1:40 PM V1 Administrator stated, "We are trying to get him to a more appropriate facility. We have referrals sent out." 10/20/23 at 3:21 PM V29, Nurse Practitioner stated, "I think he is appropriate for the facility. They are both confused. It's the staff's job to watch, and they got to him quickly and removed his hand." Care Plan Meeting note dated 7/5/23 Attendance: Administrator, Social Services, Wound Nurse, MDS/Care Plan Coordinator, Activities Invitation to Resident and Care Plan Representative: Daughter and Son-in-law Meeting Note: Family state that they are aware resident needs a more structured facility more structured for Traumatic Brain Injury (TBI) patients. Family state that they cannot care for him at home. Social services stated that they are inquiring to other facilities to meet resident's needs. It was discussed with resident's daughter some of his recent behaviors i.e.: Trying to elope, trying to take other residents out, getting more aggressive with staff. Family stated they are glad resident has come to (facility) as resident (R38) is well enough to leave facility for a facility to assist with his TBI needs. Resident	S9999		

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S9999	Continued From page 6 states he is just waiting to see what facility is found for him. Daughter was assured that staff will touch base with them and keep them in the loop as to what facilities referrals are sent to." 2. On 1/18/2023 at 10:11 AM, R13 stated he had $300.00 dollars that someone took back in January and the facility never replaced it and he did not think it was right. R13's MDS dated 1/31/2023 documents R13 was cognitively alert and orientated for activities of daily living. Investigation Report undated documents, "Social Service Director (SSD) spoke with (R13). (R13) stated that the last time he saw his $300.00 was about nine days ago. He had three one-hundred-dollar bills in his wallet which he kept under the seat of his rollator walker. He did not see anyone else in the room besides the aids and nurses. He denies giving anyone any money." Statement V15, Housekeeping Supervisor dated 1/12/2023 documents, "To whom it may concern: I (V15) is [sic] aware that resident (R13) kept three $100.00 dollar bills in his blue walker, zip up pocket. (R13) has had this amount of money for quite sometimes as he showed me back in April of 2021." Facility Incident Report event occurred 1/5/2023 at 11:30 AM, "Resident reported to staff alleged misappropriation of resident funds." Statement from V16, Physical Therapist, dated 1/11/2023 documents, "I (V16), was asked by (R13) on an unknown date in December to get $1.00 out of patient's wallet to give resident to buy	S9999		

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a soda. When retrieving the dollars in his wallet. I asked if he was aware of the money and he said, 'yes.' I also educated resident that he can give the money to facility staff to keep in safe, but he declines. Last week, (R13) asked me to get him another $1.00 for a soda. He said he had $18.00 and the three $100.00 dollars, but there was no money in his wallet. Facility staff notified immediately."

On 10/24/2023 at 10:05 AM, V16 stated, "(R13) always had money in his wallet and he had a hard time opening his wallet and needed assistance to get in and out of his wallet and take the money in and out. After therapy he was always asking staff to assist him, and I know he always had three large one hundred dollar bills in his wallet along with a few dollars here and there for his sodas. He always likes to get sodas. When (R13) told me his money was missing I looked for it and we could not find his money. It makes me sad that anyone would steal from him."

On 10/18/2023 at 3:32 PM, V1, Administrator stated, "We were able to determine that (R13) had the money and we are going to be replacing the money now."

3. R4's Physician Order Sheet for April 2023 document diagnoses of chronic obstructive pulmonary disease, multiple sclerosis, abnormal posture, schizoaffective disorder, seizures, and anxiety disorder.

R4's MDS dated 3/3/2023 document R4 was cognitively alert for decision making. R4's MDS documents R4 requires extensive assistance of two staff for med mobility and transfers.

On 10/24/2023 at 9:40 AM R4 stated that when

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S9999	Continued From page 8 staff were putting her to bed, they hit her head and, on the headboard, and it surprised her and hurt her head. R4 stated "I was upset, and I told (V13 Certified Nursing Assistant) and she got mad at me and yelled at me and told me not to point my finger at her and if I did just wait and see what happens. I do not think staff should threaten me and it really did scare me. There was another CNA in the room (V12). She did not do anything." The Facility Incident Report date of Incident 4/5/2023 documents, "(V12, Certified Nursing Assistant) reported to (V1, Administrator) that while putting (R4) up in bed on Wednesday, they pulled her up too far and her head hit the headboard. (R4) pointed her finger at (V13, Certified Nursing Assistant (CNA) and told her that she did it on purpose. (V13) responded by telling her to see what happens if she points that finger at her again." R4's Final Report, undated documents Conclusion unsubstantiated. "At the conclusion of the investigation, it appears no abuse occurred. Based on witness statements, (R4's) head getting hit was not intentional. There was poor customer service in the way (V13) responded to the resident." V13's Personal File documents she was terminated from the facility on 5/8/2023 for customer service. R4's Care Plan documents does not document she is at risk for abuse. R4's Investigation documenting Date/Time Administrator was reported 4/7/2023 at 10:45 AM. Immediate Assessment: No physical injuries noted, stated she did have a headache that day	S9999		

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but no longer does. Resident states she feels safe when (V13) is not here.

The Facility Investigation report for R4 dated 4/7/2023 document, "The administrator attempted to reach (V13) but was only able to leave a voice message asking her to call the facility and speak with the Administrator. 4/11/2023 The administrator interviewed (V13) regarding the concerns reported by (R4). (V13) stated that last Wednesday while in (R4's) room, (V13) almost poked her in the eye three times. Each time (V13) did it, (R4) said that she told (V13) not to poke her or put her finger in her face. When asked if she made the statement 'see what happens if you point that finger at me again,' (V13) stated that was a lie."

A statement from V12 dated 4/7/2023 documents, "On 4/5/2023 CNA (V13) and I went to pull (R4) up in bed, and she hit her head on the headboard; we both apologized to the resident, which then started yelling out (V13) stating very upset pointing in (V13's) face yelling. (V13) became upset with resident yelling back at resident."

A statement from V14,CNA, dated 4/7/2023 documents, "I have been told by several residents that (V13) has been verbally abusive and when they ask for something she does not get it. She takes forever to answer call lights, A lot of residents have said they wait too long before their lights get answered."

The Abuse Policy and Prevention Program 2022 documents, "The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivations of goods and services by staff or

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S9999	Continued From page 10 mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals." Sexual Abuse includes, but is not limited to sexual harassment, sexual coercion, or sexual assault (42 CFR.483.12 interpretive Guidelines) including nonconsensual or noncompetent to consent sexual activity. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individual's age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines).	S9999		