STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002778	A. BUILDING: _____ B. WING _____	C 03/01/2023

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BRIA OF ALTON	3523 WICKENHAUSER ALTON, IL 62002

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S 000	Initial Comments Complaint Investigation 2341575/IL156816	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3210t) 300.3240f) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's	S9999		

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S9999	Continued From page 2 condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: A. Based on interview and record review, the facility failed to ensure residents are free from verbal and physical abuse for 6 of 7 residents (R2, R3, R4, R5, R6, R7) reviewed for abuse in the sample of 9. This failure resulted in R5 and R6 being hit with a hot cup of coffee. R5 sustained a hematoma to the head, experienced pain, anger and not wanting to be around R2. B. Based on interview and record review, the facility failed to provide behavioral health services for mental illness to maintain/improve resident's psychosocial well-being for 1 of 3 residents (R2) reviewed for behavioral health services for mental illness in the sample of 3. This resulted in R2 having ongoing behaviors of impulsive and explosive verbal and physical aggression. Findings include: R2's Face Sheet documents original admission date of 11/30/22. R2's Minimum Data Set (MDS), dated 12/12/2022, documents that R2 is cognitively intact and has verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others). R2's Care Plan, dated 1/27/23, Psychotropic	S9999		

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S9999	Continued From page 3 Meds documents: (R2) requires the use of psychotropic medication Buspirone, Ramelteon, and Geodon to assist with managing mood and behavior related to DX (diagnosis) of Insomnia, schizoaffective disorder and schizophrenia with targeted symptoms/behaviors of wakefulness, paranoia, verbal outbursts. It also documents 2/22/23 Resident attempted to throw a cup in the dining room during a meal at a specific resident. He hit two other residents instead. It continues Interventions: Geodon increased per psych (psychiatrist). Resident's assigned table in dining room moved away from both residents. 1/4/23 Resident can become accusatory of nurse's "taking his medications" when they have been DC'd (discontinued) and he was notified. It continues Interventions: Intervene when any inappropriate behavior is observed. Communicate that the resident is responsible for exercising control over impulses and behavior (Social Skills training). Use creative refocusing to alter behavioral patterns if the person suffers from Dementia (e.g., provide drawers, laundry basket for rummaging, provide a tube sock with a knot to focus the resident's attention). It also documents 2/22/23 Resident can get verbally abusive with staff. Hits nurses' carts demanding pain medications. Cusses and becomes accusatory. It also documents 1/25/23 Resident has symptoms such as mood swings, impulsive behavior and attention seeking behavior related to a diagnosis of Schizoaffective, bipolar type Disorder. Monitor for increase of signs and symptoms of increased anxiety and change in mood. R2's Nurses' Notes, dated 11/30/2022 at 7:50 PM, document: Note Text: patient arrived via ems (emergency medical services). patient is alert and oriented x4 and able to verbalize needs and concerns. patient is diabetic with hx (history) of	S9999		

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S9999	Continued From page 4 cellulitis, pancreatitis, and substance abuse. patient arrived with multiple sharp blades that were taken on arrival and placed in narc (narcotic) box. patient seems pleasant, oriented to room and call light system. R2's Nurses' Notes, dated 12/1/2022 at 3:00 AM document: Late Entry: Note Text: Nurse (V15) turned in 9 knives and blades that resident (R2) voluntarily gave him. They are now in the SS (social services) office secured. R2's Care Plan does not document problem or interventions of R2 having multiple sharp blades and knives. R2's Nurses' Notes, dated 12/9/2022 at 1:33PM, document: "Note Text: resident has been very aggressive towards staff today. resident has been cussing at staff throughout the morning This resident also accused staff of taking his wallet. this nurse went into resident's room and he stated 'SOMEONE TOOK MY F****** WALLET, FIND MY F****** WALLET.' this nurse asked the resident to please stop cussing at me and then I asked him what color was his wallet and where was the last place he had it. he stated 'My WALLET IS BLACK AND I HAD IT IN THE F****** SHOWER ROOM.' CNA (Certified Nursing Assistant) staff stated they had already looked in the shower room and nothing was left in there, this nurse then looked in the resident's bedside dresser and seen a black wallet in the drawer. I showed him the wallet and asked him was this his black wallet, resident then apologized and stated 'yes it is; somebody must have put it in there when I left out of the room.' resident had not left out the room since he had his shower. nothing was missing out of the resident wallet."	S9999		

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S9999	Continued From page 5 R2's Nurses' Notes, dated 12/27/2022 8:02 PM document: "eMAR (electronic Medication Administration Record) - Shift Level Administration Note Text: Resident is verbally aggressive with this nurse regarding unfulfilled oxycodone script. Resident states that he has been out of the medication for 9 days. Resident called corporate hotline after this nurse told him that he needed a new script for the medication. Resident started screaming that he was going to get it one way or another or that he would just go back to the emergency room. This nurse notified (V14) NP (Nurse Practitioner) and NP stated that she doesn't write scripts after 8:00PM and she will be in at 8:30 am tomorrow morning to see resident. Administrator made aware of conversation." R2's Nurses' Notes, dated 12/31/2022 at 1:06 PM, document: "Note Text: resident was brought the wrong tray for lunch by accident. resident started yelling and screaming and cussing, resident was walking back from the dining room. this resident then told another resident to get the f*** out his way. this nurse went into resident's room and asked resident who delivered the hall tray. he stated some short person gave him one. this nurse tried to explain to resident that he had the wrong tray and that's why his food was not double portioned. this resident then continued to cuss and yell, this nurse told resident that he needed to not yell and to lower his voice, I explained to him that I was not yelling at him so he did not need to yell at me. he responded "I'M GONNA SAY WHAT THE F*** I WANT TO SAY, I'M TIRED OF THIS SH** EVERY F****** DAY." this nurse then told this resident he can state what he needs to state but he will do it without yelling. we have other residents on the hall that don't deserve to be in a disruptive environment.	S9999		

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resident then stated 'F*** THIS SH**.' this nurse stated once again that he needed to calm his voice down and stop yelling, Resident kept yelling. this nurse then tried to show this resident the name on the meal ticket to confirm to him that he had gotten the wrong tray by mistake. resident then started to yell stating 'SO YOU THINK I CAN F****** READ THAT?' I told him ok, you can sit in here and calm down. I will shut your door until you do. Resident stated 'SHUT THE F****** DOOR.' resident kept cussing and screaming; this nurse walked out of resident room and closed the door. this nurse will go back to talk to resident about the mistake that was made on his food tray once this resident calms down."

No new interventions added for aggression noted on 12/27/22 and 12/31/22.

R2's Nurses Notes, dated 1/19/2023 at 10:30 AM, documents, "Note Text: Today I was notified by a CNA that (R2's) room smelled like cigarette smoke and requested that I come and speak to him. I went to his room which indeed smelled of cigarette smoke. I asked him if he had been smoking and he stated no. I asked him to come to my office and have him to sign the (facility's) Smoking Policy which he agreed to. I read to him the entire policy because he stated that he has a hard time seeing. Later a room sweep was done with the DON/ADON (Director of Nursing/Assistant Director of Nursing) and a cigarette/lighters/empty cigarette boxes/Butane Canister were found. Also, a black case that was found that he refused to open resulting in the (local) police assistance was needed because of (R2's) aggressive behavior. In result, the black box was locked inside the nurse cart on the hall."

R2's Nurses' Notes, dated 1/19/2023 at 2:14 PM,

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documents "Social Service Note Text: room was searched by DON, ADON and social services. We found cigarettes, 2 lighters, a butane torch with a canister and a locked box. He was given the option to open it or allow us to remove the box for safety and he became irate. We were unsuccessful at calming him down. The police was notified r/t (related to) aggression towards staff. Lock box removed from the room once police arrived. Resident was taken outside by staff to smoke and an attempt to calm down. Guest was placed on q (every) 15 min (minute) checks x 72 hours. His BIMS (Brief Interview for Mental Status) score is 15. Social services educated and a signed a smoking policy was given in addition to being educated on appropriate smoking areas. He is self responsible. MD (physician) notified."

No timely progressive interventions added for aggression noted on 1/19/2023, 2/5/2023, and 2/17/2023.

R2's Nurses' Notes, dated 1/26/2023 12:02, document: "Note Text: resident with complaint of depression. psych (psychiatrist) made aware."

R2's Nurses' Notes, dated 2/5/2023 at 1:38 PM, document: "Note Text: resident noted to have w/c (wheelchair) belonging to hospice resident. this nurse returned w/c to rightful owner, while replacing a different w/c to resident. resident became belligerent calling the (local police department). Upon speaking with (local police department) resident continued to talk loudly. (local police department) officer advised resident to lower his voice. resident was told by (local police department) w/c was inspected and did not belong to him. resident became loud with (local police department) officer. (local police

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department) officer re-directed resident telling him w/c was replaced. resident stated it wasn't his w/c and he would eventually get the other w/c (wheelchair) back. (local police department) officer advised resident not to try it or there could be consequences. resident walked away from (local police department) officer and returned to room. resident sitting in room at this time."

R2's Nurses' Notes, dated 2/17/2023 2:45 PM, document: "Note Text: resident complaining of back pain. resident was offered over the counter pain meds that he has scheduled. resident refused and stated those medications do not work. this nurse explained to the resident that the other medication had been d/c (discontinued) and I could not give medication that I do not have an order for. Resident started yelling and screaming stating this was bullsh** and he doesn't understand why they would D/C his medication in the first place. this nurse told resident I would contact the doctor to see what we could give him. resident yelled f*** this sh** and punched the treatment cart. resident was redirected to his room, where he went and laid down in his bed to calm down."

R2's Nurses' Notes, dated 2/17/2023 at 6:08 PM, document "Note Text: (R2) and another resident exchanged a few words back and forth, the other resident called for (V12, Human Resources) to come over and get the resident because he had came in the dining room starting stuff; this nurse (V13, Licensed Practical Nurse/LPN) and V12 walked over to see what was going on, by the time this nurse and V12 made it over to the residents, (R2) got more upset and tried throwing his coffee cup at the other resident; the coffee cup ended up hitting a different resident in the head and bouncing off of him and hitting another

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resident in the shoulder; this nurse as well as other staff members redirected the residents. (R2) was instructed to go back to his room so he could calm down. This resident was sent out to the hospital for a psych eval, EMT (Emergency Medical Technician) called, resident going to (local hospital) for further evaluation. (V14) NP (Nurse Practitioner), (V1), Administrator made aware."

The facility's Follow-up Investigation Report, not dated, documents "Interview with (R2) reveal that him and (R7) were having a disagreement about their shared bathroom and (R2) does not deny swinging his cup in attempt to hit (R7) with it and he missed and accidentally hit (R5). (R2) was apologetic for his actions and was educated about his inappropriate behavior." It also documents Conclusion of the investigation: "On 2/17/2023 @approximately 4:50pm, staff reported possible resident to resident physical altercation physical altercation between (R2) a 46 yr old male whose diagnosis includes Schizoaffective Disorder, Bipolar Type and (R5) a 75 yr old male whose diagnosis including Cognitive Communication Deficit. While in dining room preparing for dinner meal, (R7) and (R2) were having an argument about their shared bathroom when (R2) tossed his coffee cup at (R7) missing him and making contact with (R5's) forehead. The cup did bounce off (R5's) head and make contact with (R6's), a fellow peer, right shoulder however she has no injuries or psychosocial harm.

On 2/27/2023 at 11:38 AM, R2 stated that he did throw his cup with hot coffee in it. R2 stated that R7 was poking and poking and poking at him. R2 stated that he became so upset that he threw the cup. R2 stated that he intended to throw the cup.

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S9999	Continued From page 10 R2 stated that it was deliberate. R2 stated that it didn't hit the person (R7) that was bothering him. R2 stated, "It hit the nicest guy (R5) you could ever meet." R2 stated that he is sorry that it hit R5. R2 stated that he just wanted R7 to shut up. R2 stated that he does not eat in the dining room. R2 stated that he does go in the dining room to get coffee. On 2/27/2023 at 11:53 AM, R5 stated that he was sitting in the dining room and R2 threw a cup at his tablemate (R7). R5 stated that the cup missed him (R7) and hit (R5) in his head. R5 stated that he was upset and that it hurt. R5 stated that his head was swollen and bruised. R5 stated that he doesn't like to be hit. R5 stated that he still has some bruising to his head, and it is tender and hurts when touched. R5 stated that he doesn't want anything to do with R2. R5 stated, "He (R2) can stay over there, and I can stay over here." R5's MDS, dated 1/2/23, documents that R5 is cognitively intact. On 2/27/2023 at 3:30 PM, R1 stated that he was sitting in the dining room at the table. R1 stated that it was before supper. R1 stated that R2 was walking into the dining room. R1 stated that R2 and R7 were arguing and yelling at each other. R1 stated that R2 got mad and threw a cup of hot coffee at R7. R1 stated that the cup missed R7 and hit R5 in the head. R1 stated that it was a lot of commotion, and the staff came running asking what happened. R1 stated that the staff started asking what happened to her (R6). R1 stated that when looking R6 had gotten hit as well. R1 stated that R2 threw the cup at R7 but missed him. R1 stated that R2 is aggressive at times yells and screams and gets mad easy. R1 stated that he doesn't want to be around him (R2).	S9999		

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S9999	Continued From page 11 R1's MDS, dated 1/28/2023, documents that R1 is cognitively intact. On 2/28/2023 at 9:17 AM, R6 stated that she got hit in the head and arm by a cup. R6 stated that 2 guys were arguing, one threw the cup and it hit her. R6 stated that she doesn't want to be bothered with and doesn't care to be around R2. R2's MDS, dated 1/29/2023, documents that R6 is cognitively intact On 2/28/2023 at 9:28 AM, V5 (CNA) stated that R2 does have behaviors. V5 stated that he yells and gets upset easily. V5 stated that R2 likes coffee and if there is not coffee on the cart he gets upset. V5 stated that if his coffee is not on the hall cart, she has to go and get it for him. On 2/28/2023 at 9:31 AM, V4 (LPN) stated that R2 has behaviors. V4 stated that R2 is aggressive. V4 stated that R2 yells, screams, and gets in the personal space of the staff and residents. V4 stated that when R2 gets mad, he will leave the facility and grounds without telling anyone. V4 stated that when he is upset, she can at times talk to him and let him go through his meltdown, and then R2 apologies but then the next day it's the same thing. V4 stated that R2 likes coffee. V4 stated that R2 gets his coffee from the kitchen and walks through the facility with it. On 2/28/2023 at 9:38 AM, V6 (CNA) stated that R2 is aggressive. V6 stated that when R2 can't get his way he becomes volatile. V6 stated that R2 yells and threatens the staff. V6 stated that R2 gets in your personal space and threatens to hurt you. V6 stated that R2 does this with staff and	S9999		

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other residents in the building. V6 stated that R2 will have this behavior then later apologize. V6 stated that then the next day he does the same thing. V6 stated that the only thing she knows to do is leave him alone or if there is a specific person he is mad at, then they try to keep that person out of his room. V6 stated that R2 does carry his coffee cup with coffee in it around in the facility.

On 2/28/2023 at 11:44 AM, V10 (Dietary Aide) stated that she was passing drinks in the dining room before supper. V10 stated that R2 came in the dining room and asked her for a cup of coffee. V10 stated that R2 then stated that they wouldn't give him his pain pill. V10 stated that she gave R2 a hot cup of coffee and he started rolling away. V10 stated that R2 continued to yell about not receiving his pain medication. V10 stated that R7 told R2 to be quiet about his pain medication. V10 stated that R2 stopped and turned around and asked R7 what he said. V10 stated that R2 and R7 started yelling at each other, cursing at each other. V10 stated that R2 then threw his cup of coffee at R7. V10 stated that R2 missed R7 and hit two other residents. V10 stated that after he hit the other residents R2 started apologizing. V10 stated that R2 deliberately and intentionally threw the cup of coffee at R7.

On 2/28/2023 at 2:28 PM, V1 (Administrator) stated that he is aware of the incident that occurred. V1 stated that (R2) and (R7) were arguing in the dining room. R2 threw his cup of coffee at R7 and missed. V1 stated that the cup of coffee missed its intended target. V1 stated that the cup then hit R5 and R6. V1 stated that R5 sustained an injury. V1 stated that R5 had a hematoma to his head. V1 stated that R2 intended to hit R7. V1 stated that he had a

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	IL6002778	A. BUILDING: _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF ALTON	3523 WICKENHAUSER ALTON, IL 62002

(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
S9999	Continued From page 13 sentinel call with corporate and this incident was discussed. V1 stated that at that time this event was not viewed as abuse and because the injury was not serious the event was not reported. On 3/1/2023 at 12:05 PM, V16 (Psychiatrist) stated that he has worked with this facility for years. V16 stated that this facility was primarily skilled but within the last few years has taken more mentally ill patients. V16 stated that bipolar is a mental illness and the patients require psychosocial programs and services, whether or not it is in groups. V16 stated that the facility is to provide this service and this would be his expectation, especially if a patient is having increased uncontrolled behaviors. On 3/1/2021 at 2:00 PM, V1 (Administrator) stated that the facility does not provide any psychosocial programing or services. V1 stated that he is not saying that it is not needed, but at this time the facility does not provide that service. On 3/1/2023 at 3:28 PM, V1 stated that the facility does not have a Mental Health Psychosocial policy. On 3/1/2023 at 3:33 PM, V17 (Social Services Director/SSD) stated that she is new to the facility. V17 stated that she has only worked at the facility 6 days. V17 stated that she is working on reviewing residents but has not had the opportunity to talk with and review R2. V17 stated that she does not know of R2 having a program because she has not gotten to him yet. On 3/1/2023 at 4:02 PM, V18 (previous SSD) stated that R2 was not receiving psychosocial programing or services at the facility. V18 stated that she doesn't remember why but knows that he	S9999		

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S9999	Continued From page 14 wasn't. R3's Care Plan, dated 1/9/23, documents that 12/13/22 R3 displays behavioral symptoms related to Dementia and are manifested by agitation and verbal aggression, 1/8/2023 Resident has a history of aggressive and inappropriate behavior, and 1/8/23 Resident involved in an altercation with another resident. R3's MDS, dated 11/9/2023, documents that R3 has some moderate impairment cognitively. R3's Nurses' Notes, dated 1/8/2023 at 11:36, documents "Note Text: resident was approached by fellow resident in dining room and asked to move so fellow resident could sit at her usual table for lunch. resident smacked fellow resident, smacked her on the left side of her face. residents re-educated to appropriate behavior towards others. administrator and NP notified. psych notified as well." The facility's Follow-up Investigation Report, not dated, documents Occurrence Resolution: On 1/8/2023 @ 120p 11:00 am staff reported resident to resident physical altercation between (R3) a 70 year old male whose diagnosis includes unspecified Dementia, Unspecified Severity, without Behavioral Disturbances, Psychotic Disturbances, Mood Disturbances, and Anxiety and (R4) a 55 year old female whose diagnosis includes Unspecified psychosis not due to a substance or known physiological condition. (R3) and (R4) were on their way to the dining room for lunch when the two had a verbal altercation resulting in a physical altercation causing (R3) to make contact with (R4) left face cheek. Staff were able to intervene and separate the residents. R4 obtained a slight red tint to her face. R3 denied	S9999		

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the altercation occurred. R4 stated that R3 was in her spot, and she asked him to move. She denies being rude or in R3's face. It also documents that "Based on the results of the investigation, facility was not able to substantiate intentional abuse. Chart review reveals (R3's) diagnosis of dementia results in him having poor communication skills to communicate with (R4) to move away from him instead of making contact."

On 2/27/2023 at 2:55 PM, R3 stated that he does not remember hitting R4.

On 2/27/2023 at 3:00 PM, R4 stated that she went to the dining room. R4 stated that they have an assigned seat in the dining room. R4 stated that she asked R3 to move out of her space. R4 stated that she did get close to R3 but did not touch him. R4 stated that R3 then slapped her in the face. R4 stated, "R3 does this a lot and he likes aggravating you." R4 stated that she is frustrated and tired of it.

On 2/28/23 at 9:57 AM, V9 (Certified Nursing Assistant/CNA) stated that R3 yells and becomes agitated. V9 stated that the only time she has seen R3 be physical is in the dining room. V9 stated that R3 was sitting at a table and (R4) told him to move out of her space. V9 stated that R3 and R4 were going back and forth. V9 stated that R4 told R3 to move out of her space in the dining room, and R3 told R4 to get away from him. V9 stated that R4 told him to get out of her space and R3 slapped her. V9 stated that R3 meant to hit R4.

On 2/28/2023 at 11:49 AM, V11 (CNA) stated that she heard some commotion in the dining room. V11 stated that she was standing in the hallway. V11 stated that R4, in her wheelchair, rolled up to

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S9999	Continued From page 16 R3, knees to knees, and told R3 to get out of her space. V11 stated that R4 then pushed R3 in his chest and R3 then slapped R4. V11 stated that R3 slapped R4 on purpose, but it was after R4 pushed him. V11 stated that R4 and R3 were loud and yelling and that their actions were deliberate and intentional. The facility Abuse Policy and Prevention Program 2022, not dated, documents "This facility affirms the right if our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The 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." (B)	S9999		