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 04/20/2023

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
S 000	Initial Comments Complaint Investigation: 2343081/IL158678	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These Regulations are not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure one-on-one (1:1) supervision was implemented to prevent future accidental falls for 1 of 3 residents (R5) reviewed for fall prevention in the sample of 7. This failure resulted in R5 sustaining a fall with facial injury and laceration to his scalp and a second unwitnessed fall on 4/11/23 to his head as a result of no one-on-one supervision provided with a second emergency evaluation and treatment. Findings include: R5's, Admission Record, dated, 4/19/23, documented, the following medical diagnosis, unsteadiness on feet, abnormalities of gait, difficulty in walking, cerebral palsy, paranoid schizophrenia.	S9999		

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S9999	Continued From page 2 R5's, Nurses Note dated 3/22/23, documents, "Resident continues to be on 1:1, resident stayed in his room; on 3/23/23, R5 remains on 1:1 (one-on-one staff supervision), due to aggressive behaviors. R5's Nurses Noted dated 4/5/2023, documents, "Resident (R5), continues on 1:1, nurse continues to monitor patient through the shift. R5's, Incident Details, documents, "CNA (Certified nurse Aide) notified this nurse, on 4/8/23 at 4:08PM, because residents nurse was on break that resident launched himself from his wheelchair to the floor, resident is baseline confused. CNA stated that resident hit his head on the floor. It appeared he has some swelling of about 1/2 inch on his forehead with about a 2 cm (centimeter) cut, bleeding was cleaned and stopped. Resident was found sitting on the floor sideways, both legs slightly flexed, he was located in front of his wheelchair." R5's, Post Fall Huddle, dated 4/8/22, documented, that R5 had a witnessed fall, in his room and the cause documents: "Resident launched self to floor and further documents that R5, sustained an injury of bruise, to face, and immediate interventions documented, "Res (resident) is on 1:1 with staff to sit closer." R5's, Care Plan, dated 4/8/23, documented an intervention for this fall of, "Medication review to be performed by doctor." R5's, Nurse Note, dated 4/9/2023, documents, "Resident returned from (local hospital) via (by way of) ambulance two attendants. negative head and neck CT (Computerized Tomography) scan. No new orders. Hematoma to forehead remains	S9999		

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S9999	Continued From page 3 from fall. vss. (vital signs stable) denies pain will continue to monitor. R5's, Post Fall Huddle, date 4/11/23, documented, that R5 was alone and unattended in his room, with an attempt to walk, R5 sustained an injury of a laceration to his head. R5 was transferred to the emergency room and the Immediate intervention documented, resident is a one-on-one supervision. R5's, Incident Audit Report, dated, 4/11/23, with incident time of 9:45AM, documents, "writer was called by clinical supervisor to residents' room at approx. (approximate) 9:50AM to assess resident. Writer entered residents' room and noted resident on floor near his dresser, wheelchair beside him, resident was in the fetal position. Assessed resident and noted a large, raised area to crown of head." Further documentation that R5 complained of head and both knee pain. Physician notified to send R5 out to emergency room for evaluation and treatment. R5's, Emergency Department Triage Notes, dated 4/11/23, documents, " PT (Patient) to ED (emergency department) via (by way of) EMS (emergency medical service) from facility for c/o (complaint) a fall. Per EMS, pt. had an unwitnessed fall out of his wheelchair this morning. Pt has bruising to his forehead. R5's, Care Plan, dated 4/11/23, documented an intervention for this fall of, "Neurology consult." R5's Enhanced Supervision Monitoring Tool, (15 minute one-on-one supervision), dated 4/11/23, documented, from 6:30AM through 10:15AM, documented for the following time/location:	S9999		

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S9999	Continued From page 4 6:30AM-bed-no staff initials 6:45AM-bed-no staff initials 7:00AM-chair-no staff initials 7:15AM-chair-no staff initials 7:30AM-chair-no staff initials 7:45AM-chair-no staff initials 8:00AM-R5 was in bed until 8:45AM-no staff initials 9:00AM-R5 was in chair until 9:15AM-no staff initials 9:30AM-R5 was in bed until 9:45AM-no staff initials 10:00AM-R5 in bedroom. (Fall incident report documents 9:45AM, unwitnessed fall) The following written times and locations does not indicate, written staff initials. And further documents, at 10:15AM, R5, "hospital." On 4/19/23 at 12:36PM, V24, CNA, stated, she had worked on 4/11/23 with her shift starting at 7:00AM, when she was informed that R5 had fallen in his room without a 1:1 nursing staff to provide supervision. V24 stated, R5 is to have ongoing 1:1 supervision due to his aggressive behaviors and history of falls, with a current fall he had on 4/8/23. V24 stated, she came into work on 4/11/23 at 7:00AM, was not assigned to R5 this day for 1:1 supervision, however realized R5 was in his room without a nursing staff present for his supervision. V24 then informed V25, a (previous employee in-charge of staffing nurses), that R5 requires one on one supervision and that there was no nursing staff in his room to monitor him. V24 continues to state, that V25, had stated she had a CNA scheduled to come in at 9:00AM, to provide the one-on-one supervision for R5. V24 continued to state, the unknown nursing staff scheduled for 9:00AM had called off and then heard that R5 had fallen in his room and	S9999		

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S9999	Continued From page 5 sent out to a local hospital. V24, stated, that one-on-one supervision requires, to be at the resident side and document supervision every 15 minutes. On 4/20/23 at 2:10PM, V15, Registered Nurse, stated, R5 did not have 1:1 supervision, as there was no staff available to perform the 1:1. R5 wanted to lay down, therefore he was taken to his room. V15, stated, R5 did not have anyone present in his room to do 1:1 supervise with him, and she had to administered medication to other residents but would check on him. On 4/19/23 at 2:05PM, V1, Administrator, stated, this incident occurred two days after undergoing Administrator status at this facility, unaware of the incident but R5 should have been and remained on one-on-one supervision status. The facility presented, documentation, entitled, "Attestation," dated, 4/20/23, signed by V26, Corporate Nurse, documented, R5 experienced a fall on 4/8/23 and 4/11/23. The resident was sent to the local ER (emergency room) out of an abundance of caution and desire to obtain CT scan to identify any underlying concerns. This should not be deemed a negative outcome. Both visits resulted in the residents return to facility with no new orders required. This resident did and does not have an order for enhanced supervision nor is this a care planned fall intervention. The resident is monitored at the nurse's discretion that is on shift according to his behaviors. The facility presented, documentation, entitled, "Attestation," dated 4/20/23, signed by V26. documents, "This should not be deemed a negative outcome. Both visits resulted in the	S9999		

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S9999	Continued From page 6 residents return to facility with no new orders required. This resident did and does not have an order for enhanced supervision nor is this a care planned fall intervention. The resident is monitored at the nurse's discretion that is on shift according to his behaviors. The facility presented, documentation, entitled, "Attestation,", dated 4/19/23, written and signed by V15, documents, "I (V15), was (R5) nurse on 4/11/23. Resident was at nursing station in wheelchair, and I was at my med. (medication) cart. Resident requested to go lay down, as I note him to be calm, cooperative and head bobbing, with occasional snoring noted. I asked another staff member to lay him down and between myself and other staff we wanted do 15 min (minute) checks." The facility's policy and procedure, entitled, "Residents' Rights and Residents' Safety, Enhanced Supervision Guidelines, revision date of 7/8/2020, documented and entitled, "one to one observation," documents, "one staff member will be scheduled to provide one to one observation. The scheduled staff member will not have other resident in his/her care assignment. This is an integral part of a therapeutic plan and ensures the safe and sensitive monitoring of the patients' physical and psychological wellbeing. The facility will utilize the "Enhance Supervision Monitoring Tool," form to document the enhanced supervision provide to the resident. The staff will document the location and activity or behavior of the resident. When a resident has been assessed by facility staff to have decompensated and requiring more observation, the attending physician will be notified to obtain order for treatment and enhance supervision, as needed."	S9999		

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S9999	Continued From page 7 (B)	S9999		