(X6) DATE

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	DENTI TO THE WILLIAM		A. BUILDING:		C		
		IL6002778	B. WING		1	09/24/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BRIA OF ALTON 3523 WICK				R			
O(A) ID	STIMMADV STA	ALTON, IL		PROVIDER'S PLAN OF CORRECTION	<u> </u>	(V5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Complaint Investiga 2447410/IL178046	ation:					
S9999	Final Observations		S9999				
	Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210d)3)  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						
	care and services to practicable physical well-being of the research resident's complan. Adequate and care and personal coresident to meet the	shall provide the necessary of attain or maintain the highest land, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/17/24 **Electronically Signed** 

TITLE

Illinois Department of Public Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED		
						,		
IL6002778		B. WING		1	, 4/2024			
		120002770			03/2	4/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
		3523 WIC	KENHAUSEI	र				
BRIA OF	ALTON	ALTON, II	62002					
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	)N	(VE)		
(X4) ID PREFIX	_	/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE		
				DEFICIENCY)				
S9999	Continued From pa	ne 1	S9999					
00000	Continued i form pa		30000					
		ude, at a minimum, the						
	following procedure	es:						
		personnel shall assist and						
		s so that a resident's abilities						
		living do not diminish unless						
		ne individual's clinical condition						
		minution 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.							
	good nutrition, groo	ming, and personal nyglene.						
	5) All nursing personnel shall assist and							
		s with ambulation and safe						
		s often as necessary in an						
		retain or maintain their highest						
	practicable level of							
	pradudable level of	ranouoring.						
	d) Pursuant to subsection (a), general							
		nclude, at a minimum, the						
		be practiced on a 24-hour,						
	seven-day-a-week							
	au, a moon							
	3) Objective of	bservations of changes in a						
		, including mental and						
		, as a means for analyzing and						
	determining care re	equired and the need for						
		luation and treatment shall be						
	made by nursing st	aff and recorded in the						
	resident's medical r							
	These Regulations	are not met as evidenced by:						
	_							
		ion, interview, and record						
		ailed to provide toileting to						
	promote resident's	dignity for 1 of 3 residents						

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
IL6002778		B. WING		09/24/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	ALTON	3523 WIC ALTON, IL	KENHAUSEI	₹		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	(R3) reviewed for dignity in a sample of 8. This failure caused R3 to be incontinent and feel helpless, ashamed, embarrassed, depressed, and demeaned.					
	Findings include:					
	R3's Care Plan, dated 9/3/2024, does not address R3's toileting.					
	R3's Minimum Data Set, dated 8/30/2024, documents that R3 is cognitively intact, frequently incontinent of urine and bowel and independent with toileting.					
	stated that R3 is he is his power of attorown decisions. V17 called her and told of his care. V17 stated that R3 but the facility had in V17 stated that R3 fluids. V17 stated that it's yourself because yourself yourself because yourself because yourself because yourself because yourself because yourself yourse	:14 PM V17, R3's sister, or brother. V17 stated that she mey but that R3 makes his stated that her brother has her of the horrible conditions ted that R3 was embarrassed. wants to go to the bathroom no way to get him on a toilet, had to lay in his own body hat this had to be humiliating, one thing to have to go on ou can't control it but to have we no way to take you to the le.				
	originally at home. and was in the hos that he was then track R3 stated that at thalmost daily. R3 states ome of his strengt facility they had a hand he was able to	56 PM R3 stated that he was R3 stated that he became ill bital for some time. R3 stated ansferred to a rehab facility. At facility he received Therapy atted that he had regained h back. R3 stated that at the andicap accessible bathroom, hold on to the rail and get on that once his insurance ran				

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illinois Department of Public Health								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED				
						•		
IL6002778		B. WING		09/24/2024				
					1 00/2	1/2021		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
BRIA OF	ALTON		KENHAUSEI	R				
		ALTON, IL	62002					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
S9999	Continued From pa	ge 3	S9999					
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER  (X2) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER  (X3) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER  (X4) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER  (X5) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER  (X6) PROVIDER/SUPPLIER, IDENTIFICATION NUMBER  (X7) PROVIDER/SUPPLIER	DED: I`´	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			С	
IL6002778	B. WING		09/24/2024	
	STREET ADDRESS, CITY, ST	,		
RRIA OF ALLON	3523 WICKENHAUSER ALTON, IL 62002			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATI	JLL PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
On 9/18/2024 at 9:40 AM V10, CNA, state R3 had a commode in his room but it was used. V10 stated that it still had the plastic On 9/19/2024 at 3:47 PM V18, CNA, state she took care of R3, and he was a full bod mechanical lift. V18 stated that R3 was incontinent and not taken to the bathroom stated that R3 did not use a urinal or bedrested that R3 uses a full body mechanical transfer. V18 stated that residents that us body mechanical lift are usually incontiner stated that R3's wheelchair could not fit the bathroom.  On 9/19/2024 at 3:49 PM V19, CNA, state she did not care for R3 but was familiar wand his care. V19 stated that he used a fumechanical lifts do not fit in the bathroom are too big". V19 stated that they give the residents urinals and bed pans.  On 9/24/2024 3:37 PM V1, Administrator, that she expects her staff to assist resident the toilet. V1 stated that she expects if the resident can't use the toilet to be provided urinal and bedpan.  The facility's Resident Rights policy, dated 2/2024, documents "The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, well-being to the extent possible in accord with the resident's own needs and prefere continues "PROCEDURE: I. The facility assess and interview resident for the need make reasonable accommodations such	s not c on it. ed that dy  I. V18 Dan.			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6002778		B. WING		C <b>09/24/2024</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	ALTON		KENHAUSEI	R		
	I	ALTON, II				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
59999	Room set-up and A maintain/restore restunctioning."  The facility's Activity 9/2023, documents assistance and inst planned and implement and adaptive equiping Occupational There	daptive devices necessary to sident at their highest level of y of Daily Living policy, dated GUIDELINE: 2. A program of ructions in ADL skills is care nented. 3. Assistive devices ment are provided by apy. It also documents D. otive equipment, assistance	Эавая			

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