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 02/09/2024

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 Investigations: 2440937/IL169428: F580, F684, F689 2440936/IL169427: F580, F684, F689	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)6) 1 of 2 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	S9999		

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 02/09/2024

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 1	S9999		

of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
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.

This requirement was not met as evidence by:

Based on interview and record review the facility failed to timely assess, timely notify physician of resident's increased pain, and timely treat a fracture for of 1 of 3 residents (R3) reviewed for quality of care in the sample of 4. This failure resulted in R3 having leg pain from at least 1/23 through 1/28/24 and being admitted to hospital for right femur fracture requiring surgery.

Findings include:

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 02/09/2024

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 2	S9999		

R3's Face Sheet, undated, documented she had diagnoses of other lack of coordination, abnormal posture, muscle weakness, hemiplegia (paralysis on one side of body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following unspecified cerebrovascular disease affecting right dominant side.

R3's Care Plan, dated 10/24/22, documents "(R3) has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Hemiplegia. Her primary mode of locomotion is wc (wheelchair). She is incontinent of B&B (bowel and bladder). She requires assist with adl care tasks. (R3) has been provided with a reacher to assist with safely reaching personal items." It continues: "TRANSFER: (R3) requires Mechanical Aid (full body mechanical lift) for transfers. Imitation date of 9/4/2019"

R3's Minimum Data Set (MDS), dated 1/6/24, documents that R3 is cognitively intact, and dependent on staff for transfers.

R3's Nursing Progress Notes, dated 1/27/2024 at 4:52 AM, documents "resident complains of right knee pain. resident states the pain is a 10 on a 1-10 pain scale. resident states she is unable to attend dialysis this am because she can't move her right leg because the pain is so severe. this nurse asked the resident if anything had happened causing the pain in her right knee. resident states a few nights ago while being put in bed, her right leg was accidentally injured in a twisting motion. m.d. (Doctor of Medicine) made aware, poa (Power of Attorney) made aware and orders were received to order an xray of her right knee."

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 02/09/2024

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 3	S9999		

R3's Nursing Progress Notes, dated 1/28/2024 at 7:28 AM, documents "call placed to md xray to shift, care continues."

R3's Nursing Progress Notes, dated 1/28/2024 at 12:19 PM, documents "(Emergency Medical Transportation Company) is en (in) route to take resident to (Local Hospital) related to right knee xray."

R3's Nursing Progress Notes, dated 1/28/2024 at 11:56 PM, documents "This nurse called (local hospital) and spoke with (V4), RN (Registered Nurse), patient was transferred to Regional Hospital from (local hospital) with a dx (diagnosis): fractured femur. This nurse called and spoke with (V5), RN, at Regional Hospital resident is currently admitted with a fracture of the right femur with surgical intervention pending. m.d, poa and management made aware."

R3's Computer Tomography (CT) of Right Femur from (local hospital), dated 1/28/2024, documents IMPRESSION: "There is an oblique fracture (bone is broken at an angle) through the distal (furthest away from the center of the body) diaphysis (middle) of the right femur with mild posterior displacement of the distal fracture fragment and mild overlap. This is primarily in oblique fracture with mild comminution (broken in more than two pieces). A subtle component of the fracture extends distally into the distal fracture fragment along the more medial aspect (toward the middle or center) of the distal medial femoral diaphysis just above the medial femoral condyle (area located on the end of the femur/thigh bone, covered by cartilage and work as a shock absorber)."

R3's Nursing Progress Notes, dated 1/29/2024 at

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 02/09/2024

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 4	S9999		

11:31 AM, documents " This (V7), RN, called (V6, R3's POA), (listed as POA and emergency contact). (V6) told this RN that (R3) is out of surgery this morning and is currently recovering. Family is at hospital with resident at this time. Family given this RN's information and educated to reach out with updates or if they need anything."

R3's Post Fall Huddle, not dated, documents that the date of the Fall/transfer, was 1/27/2024 evenings. It documents that R3 was being transfer assisted by staff. It documents that that R3 is alert and oriented. Documents that assisted devices wheelchair was in use and device not in use. It also documents that R3 said that her leg was twisted during transfer. It documents "What appears to be the initial root cause of the fall? Resident stated while she was being put to bed her right leg was twisted 0 (no) initial pain.

The facility's Reported Incident Form Initial Report documents the date and time when the alleged incident occurred is unknown at this time. The Report documented the incident occurred in the resident's room. It documents that the serious bodily injury occurred was a right femur fracture. It documents that the Resident had increasing complaints of pain to the right leg, that was unrelieved with pharmacological intervention.

The Facility's Final Report, submitted on 2/5/24, documented the conclusion of the investigation as "After complete and thorough investigation, resident and staff interviews, the facility has concluded that the resident sustained a right femur fracture during a transfer from the resident's wheelchair to her bed. The resident states that during her transfer, the right leg became twisted. Pain was voiced in the days

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 02/09/2024

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 5	S9999		

following the incident unrelieved. The physician was notified and the resident was sent to the Emergency Room and was diagnosed with fracture of the right femur. In conclusion, it is verified that the resident sustained an injury to the right femur during transfer."

R3's Medication Administration Record, dated 1/1/2024-1/31/2023, documents on 1/23/2024 at 1:30 PM R3's pain level was #6 (1-10 with 10 being the most severe pain) and Tramadol 50, milligrams (mg) given. On 1/26/24 at 4:44 PM R3's pain level was #8.

R3's Controlled Drug Receipt Record/Disposition Form, dated 8/8/2023, documents that R3 received Tramadol 50mg tabs: 1/23/24 12 PM, 1/25/24 4:30 PM, 1/26/24 5 PM, 1/27/2023 at 5 AM and 9 PM.

On 2/6/2024 at 10:40 AM V27, Dialysis Registered Nurse, RN, stated that when R3 came to dialysis on 1/23/24 she was complaining of pain to her right leg. V27 stated that this is unusual because R3 doesn't usually complain of pain. V27 stated that she gave R3 some Tylenol. V27 stated that R3 stated that her leg was hurting because it got bent. V27 stated that R3 did not elaborate at that time. V27 stated that R3 is alert and reliable. V27 stated that at times her words may come out jumbled or garbled. V27 stated that there wasn't any bruising at the time but that there was swelling but not a large amount.

On 2/8/2024 at 1:56 PM V20, Licensed Practical Nurse, LPN, stated that on 1/23/2024 R3 complained of knee pain. V20 stated that she asked R3 what caused her pain. V20 stated that R3 reported that her leg had been bent or twisted during a transfer. V20 stated that this was new for

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 02/09/2024

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 6	S9999		

R3. V20 stated that R3 had never complained of pain before that day to V20. V20 stated that she did not look at or assess R3's knee at that time. V20 stated that she did not notify the doctor because R3 had prn (as needed) medication already ordered.

On 2/5/2024 at 3:54 PM V12, LPN, stated that R3 is alert and oriented. V12 stated that R3 is reliable. V12 stated that R3 may get the days mixed but is not confused. V12 stated that she was notified of R3 having pain in her knee. V12 stated that R3 is dependent on staff for transfers. V12 stated that R3 requires the mechanical lift. V12 stated that a couple of Fridays ago R3 said her leg was hurting and felt like it was twisted. V12 stated that she gave her Tylenol. V12 stated that this was new and R3 had not complained of pain to her leg before this. V12 stated that she did an assessment of R3's leg and it was swollen. V12 stated that she did not notify the doctor because she contributed the swelling to the usual edema. V12 stated that she gave R3 Tylenol. V12 stated that she was not notified by the staff that R3's leg being twisted during a transfer.

On 2/5/2024 at 3:23 PM V15, Certified Nurse's Assistant, CNA, stated that he works 2 days a week at the facility. V15 stated R3 was dependent on staff for care. V15 stated that R3 has dialysis on Tuesday, Thursday, and Saturday. V15 stated that when he went in to get R3 up for Dialysis R3 refused. V15 stated that this is unlike her. V15 stated that R3 never wants to miss dialysis. V15 stated that R3 was complaining of pain. V15 stated that R3 was complaining that her leg hurt. V15 stated that this is not normal for R3. V15 stated that R3 doesn't complain of pain and that she does not miss dialysis. V15 stated that he told V10, RN. V15 stated that the same day or

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 02/09/2024

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 7	S9999		

day after R3 went to the hospital.

On 2/6/2024 at 2:30 PM V10, RN, stated that she works the night shift and on Saturday morning R3 was complaining of pain to her leg. V10 stated the leg was swollen and bruised. V10 stated that R3 was refusing to go to dialysis because of the pain. V10 stated that this was new for R3. V10 stated that she asked R3 what happened. V10 stated that R3 informed her that a few nights ago her leg was twisted. V10 stated that she called V29, Doctor, and received an order for an x ray. V10 stated that she gave R3 a pain pill about 5:00 AM. V10 stated that at 7 AM the pain had not been relieved. V10 stated that R3 was still in pain. V10 stated that she notified the oncoming nurse.

On 2/5/2024 at 3:36 PM V9, LPN, stated that she came in on Saturday at 7 PM. V9 stated that she was told in report that they were waiting for xray and that R3 had swelling and bruising to her knee. V9 stated that she went down and assessed the knee, and it was puffy and bruised. V9 stated that R3 was complaining of pain. V9 stated that R3 does have chronic edema to her leg but this was different. V9 stated that R3 is alert and reliable. V9 stated that R3 does not have any history of making false allegations. V9 stated because the x ray technician hadn't been out there, she called. V9 stated that they returned her call close to 11 PM and said they were not able to get someone out to facility and rescheduled x ray to the following day.

On 2/5/2024 at 9:17 AM V6, R3's daughter, stated that her husband had come to visit R3. R3 at that time complained of pain to her right knee to him. V6 stated R3 said she was being transferred either from bed to chair or chair to bed and she was dropped. V6 stated that her

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 02/09/2024

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 8	S9999		

husband reported this to V18, CNA. V6 stated that V18 asked R3 at that time if she was dropped or hurt during the transfer, which we found kind of odd. V6 stated that the leg was swollen and bruised that day. V6 stated that she came on the following day and R3's leg was swollen and bruised and R3 was continuing to complain of pain. V6 stated she talked with the nurse and was told that x-rays were ordered but had not come yet. V6 stated at that time she and her sister requested R3 be sent to the hospital because R3 was in so much pain. V6 stated that she spoke with V1, Administrator, after R3 was admitted to the hospital for a broken femur and was informed that V1 was not aware of the issue until Monday morning. V6 stated that she was told by V1 that she would be investigating and would return a call to her. V6 stated that she has not received a call as of yet. V6 stated that her mother initially was transferred to (local hospital) and was then transferred to (Regional Hospital) where R3 underwent surgery for a broken femur. V6 stated that R3 told her that a large black woman with braids transferred her on the evening or night shift. V6 stated that R3 told her that her leg got twisted and that it hurts. V6 stated that she was not sure if R3 said she was dropped or not. V6 stated that R3 will not return to this facility and is currently at another facility.

On 2/6/2024 at 10:48 AM R3 stated that her leg got bent and twisted. R3 stated that it was dark. R3 stated that 2 girls came in and got her up. R3 stated that she was lifted by the girls and when they turned her, (R3), her leg got twisted and bent back. R3 stated that this caused her to sit down hard, and it hurt. R3 stated that it was a lot of pain when it happened and then less. R3 stated that she went to dialysis that day and it started hurting worse. R3 stated that she told the nurse and that

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 02/09/2024

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 9	S9999		

she got Tylenol. R3 stated that it helped but the pain never went away. R3 stated that the pain never went away and that she was always in pain. R3 stated that she kept telling the staff. R3 stated that she would tell anyone she could because it hurt so bad. R3 stated that when they moved her it hurt worse. R3 stated that even though she told them they continued to transfer her without the lift. R3 stated that this caused more pain. R3 stated that she remembers her son in law coming to visit and then her daughters. R3 stated that they were supposed to use the lift and didn't. R3 stated that she told the nurse. R3 stated that she was in a lot of pain. R3 stated that she doesn't remember the day but knows it was before she went to dialysis. R3 stated that she told the nurse.

On 2/8/2024 at 1:19 PM V29, Doctor, stated that he was notified of R3 having pain, swelling and bruising to her right knee and leg on 1/27/2024 and ordered x rays at that time. V29 stated that was unable to follow R3 after that as the facility went with a different physician. V29 stated that up to that point R3 was his patient. V29 stated that he would have expected to be notified of R3's new pain when it occurred. V29 stated that he would have expected the nurse to assess the patient and notify him. V29 stated at that time he would have ordered the x ray and the results of femur fracture would have been found and treatment would have started at that time, including send R3 to the hospital. V29 stated that if the staff were aware of R3 having new pain and stating that she was hurt, leg twisted or bent he would have expected to be notified of this when the nurse became aware of it. V29 stated not being notified of R3's complaints of pain and an initial assessment being performed by the nurse caused a delay in treatment.

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 02/09/2024

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 10	S9999		

On 2/9/2023 at 10:10 AM V2, Director of Nursing, stated that per their investigation the injury occurred on the 1/22/24. V2 stated that the first complaint of pain was on 1/23/24. V2 stated that she would have expected the nurse to assess R3 and notify the physician at that time. V2 stated that R3's complaint of new pain and reporting of her leg being hurt was a change in condition. V2 stated that R3 reporting that her leg was twisted or bent causing her pain is an accident or incident and the physician should have been notified at that time.

The facility's Pain Management policy, dated 9/2022, documents "Policy: 5. Licensed Nursing may notify Health Care Provider of any new development of pain, change in pain, change in condition that could cause pain, for pharmacological interventions based on the individual pain factors."

The facility's Change in Resident Condition policy, dated 9/2023, documents "It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: a. The resident is involved in an accident or incident and although it's not an emergency it was an acute medical condition."

The facility's Physician Notification policy, dated 9/2023, documents "Guideline: In a non-emergent, but acute medical situation the physician will be paged and if there is no return call in 15 minutes, the physician will be notified again. If there is no return call in 15 additional minutes (30 minutes total), the Medical Director will be notified."

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 02/09/2024

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 11 (A) Statement of Licensure Violations 2 of 2: 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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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 02/09/2024

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 12	S9999		

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.

Based on interview and record review the facility failed to safely transfer a resident per plan of care for 1 of 3 residents (R3) reviewed for supervision to prevent accidents in the sample of 4. This failure resulted in R3's sustaining a right femur fracture which required surgical repairment.

Findings include:

R3's Face Sheet, undated, documented she had diagnoses of other lack of coordination, abnormal posture, muscle weakness, hemiplegia (paralysis on one side of body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following unspecified cerebrovascular disease affecting right dominant side.

R3's Care Plan, dated 10/24/22, documents "(R3) has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Hemiplegia. Her primary mode of locomotion is wc (wheelchair). She is incontinent of B&B (bowel and bladder). She requires assist with adl care tasks. (R3) has been provided with a reacher to assist with safely reaching personal items." It continues: "TRANSFER: (R3) requires Mechanical Aid (full body mechanical lift) for transfers. Imitation date of 9/4/2019"

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 02/09/2024

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	S9999		

R3's Minimum Data Set (MDS), dated 1/6/24, documents that R3 is cognitively intact, and dependent on staff for transfers.

R3's Nursing Progress Notes, dated 1/27/2024 at 4:52 AM, documents "resident complains of right knee pain. resident states the pain is a 10 on a 1-10 pain scale. resident states she is unable to attend dialysis this am because she can't move her right leg because the pain is so severe. this nurse asked the resident if anything had happened causing the pain in her right knee. resident states a few nights ago while being put in bed, her right leg was accidentally injured in a twisting motion. m.d. (Doctor of Medicine) made aware, poa (Power of Attorney) made aware and orders were received to order an xray of her right knee."

R3's Nursing Progress Notes, dated 1/28/2024 at 7:28 AM, documents "call placed to md xray to shift, care continues."

R3's Nursing Progress Notes, dated 1/28/2024 at 12:19 PM, documents "(Emergency Medical Transportation Company) is en (in) route to take resident to (Local Hospital) related to right knee xray."

R3's Nursing Progress Notes, dated 1/28/2024 at 11:56 PM, documents "this nurse called (local hospital) and spoke with (V4), RN (Registered Nurse), patient was transferred to Regional Hospital from (local hospital) with a dx (diagnosis): fractured femur. This nurse called and spoke with (V5), RN, at Regional Hospital resident is currently admitted with a fracture of the right femur with surgical intervention pending. m.d, poa and management made aware."

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 02/09/2024

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 14	S9999		

R3's Computer Tomography (CT) of Right Femur from (local hospital), dated 1/28/2024, documents IMPRESSION: "There is an oblique fracture (bone is broken at an angle) through the distal (furthest away from the center of the body) diaphysis (middle) of the right femur with mild posterior displacement of the distal fracture fragment and mild overlap. This is primarily in oblique fracture with mild comminution (broken in more than two pieces). A subtle component of the fracture extends distally into the distal fracture fragment along the more medial aspect (toward the middle or center) of the distal medial femoral diaphysis just above the medial femoral condyle (area located on the end of the femur/thigh bone, covered by cartilage and work as a shock absorber)."

R3's Nursing Progress Notes, dated 1/29/2024 at 11:31 AM, documents " This (V7), RN, called (V6, R3's POA), (listed as POA and emergency contact). (V6) told this RN that (R3) is out of surgery this morning and is currently recovering. Family is at hospital with resident at this time. Family given this RN's information and educated to reach out with updates or if they need anything."

R3's Post Fall Huddle, not dated, documents that the date of the Fall/transfer, was 1/27/2024 evenings. It documents that R3 was being transfer assisted by staff. It documents that that R3 is alert and oriented. Documents that assisted devices wheelchair was in use and device not in use. It also documents that R3 said that her leg was twisted during transfer. It documents "What appears to be the initial root cause of the fall? Resident stated while she was being put to bed her right leg was twisted 0 (no) initial pain.

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 02/09/2024

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 15	S9999		

The facility's Reported Incident Form Initial Report documents the date and time when the alleged incident occurred is unknown at this time. The Report documented the incident occurred in the resident's room. It documents that the serious bodily injury occurred was a right femur fracture. It documents that the Resident had increasing complaints of pain to the right leg, that was unrelieved with pharmacological intervention.

The Facility's Final Report, submitted on 2/5/24, documented the conclusion of the investigation as "After complete and thorough investigation, resident and staff interviews, the facility has concluded that the resident sustained a right femur fracture during a transfer from the resident's wheelchair to her bed. The resident states that during her transfer, the right leg became twisted. Pain was voiced in the days following the incident unrelieved. The physician was notified and the resident was sent to the Emergency Room and was diagnosed with fracture of the right femur. In conclusion, it is verified that the resident sustained an injury to the right femur during transfer."

V11's, Licensed Practical Nurse,LPN, written statement, not dated, documents "On 1/26/2024 this writer was on 400 hall doing treatments when (R3) called this writer to her room. Resident stated her leg was hurting and that it was twisted when they were getting her up. Resident unable to tell this writer what day it happened. This writer immediately went to resident's nurse (V12, Licensed Practical Nurse, LPN), and let her know of the situation. (V12) stated she would give her something for the pain and notify the doctor."

V7's, Certified Nurse's Assistant (CNA), written

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 02/09/2024

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 16	S9999		

statement regarding the incident, not dated, documents "We did a 2 person transfer on (R3). (R3) never complained of pain."

V14's, CNA, written statement, not dated, documents "I worked with another CNA named (V15) over on the women side. (R3) had her call light on to go to bed. When we brought the (mechanical lift) in there she said to be careful of her right leg that midnights 2 maned her and she twisted her leg. I informed the nurse (V12) on what (R3) said. She (V12) said she already looked at it. That it was the side she had her stroke on. She didn't say anything about what I told her about midnights 2 manning her (R3)."

On 2/5/2024 at 12:39 PM V16, Scheduler, stated that the interviews and statements were from the date of 1/31/2024. V16 stated that the night that V13 transferred R3 was 1/22/24.

On 2/5/2024 at 4:14 PM V3, Assistant Director of Nursing, (ADON), stated that the investigation concluded that R3's leg was injured during a transfer. V3 stated that on 1/22/23, V22 and V23 were observed entering R3's room and transferred R3 to bed. V3 stated that V22 and V23 transferred R3 using the lift and somehow twisted R3's leg. V3 stated that watching the camera they could see them enter the room and shortly after exit. V3 stated after this transfer R3 started to complain of pain to her knee. V3 stated that there aren't cameras in the room so the exact technique she is not sure of. When asked how she knew it was a transfer with a lift, V3 stated that because R3 requires a mechanical lift she assumed the transfer was with the lift. V3 stated that R3 is alert and able to tell you what happened. V3 stated that they did Inservice on how to use the mechanical lift. V3 stated that this

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 02/09/2024

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 17	S9999		

is the only in-service performed because of R3's incident and injury.

On 2/5/2024 at 3:11 PM V14, CNA, stated that she believes she took care of R3 the day after it happened. V14 stated that she worked 3 to 11PM that night. V14 stated that R3 had her call light on. V14 stated that when she answered it R3 wanted to go to bed. V14 stated that R3 told her that she must get the lift. V14 stated that she was going to go get. V14 stated that R3 then said that they dropped her (R3) this morning. V14 stated that when they transferred R3 to the bed in lift and R3 was yelling out in pain. V14 stated that R3's leg was swollen. V14 stated that she told V12 and V12 response was that she already knew and that its R3's flaccid leg. V14 stated that it is not like R3 to complain of pain and to yell was different and new. V14 stated that R3 is alert and able to respond correctly. R3 stated that if R3 said she was hurt or dropped than its accurate.

On 2/5/2024 at 3:18 PM V11, Wound Nurse, stated that she worked the floor as an aide on 1/22/24 because of the ice storm. V11 stated that she assisted R3 with repositioning and care and R3 did not complain of any pain. V11 stated that R3 leg had some edema. V11 stated that this is not unusual for her because of her right side being flaccid. V11 stated that she did not see any bruising. V11 stated on the following Friday (1/26/24) R3 yelled for V11 to her room. V11 stated that R3 stated "I'm in pain. They twisted my leg when getting me up." V11 stated that she reported this to V12. V11 stated that she informed V12 of the pain and of R3 saying that her leg was twisted when staff got her up. V12 stated that she will assess her and call the doctor. V11 stated that she did not look at R3's leg at that time. V11 stated that R3 is very alert. V11 stated she

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 02/09/2024

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 18	S9999		

believes R3's statements are accurate. V11 stated that R3 can remember things from a week before. V11 stated that R3 does not have a history of making false allegations. V11 stated that if R3 said she would believe it to be accurate.

On 2/5/2024 at 10:36 PM V26, CNA, stated that she works at the facility fulltime. V26 stated that she is familiar with R3 and provides care for her routinely. V26 stated that R3 is dependent with care. When asked how does R3 transfer, V26 responded that she was told to use 2 people, but she uses the mechanical lift because R3 doesn't stand. V26 stated that about 2 weeks ago V26 was getting ready to get R3 up. V26 stated that V13 was working the shift as well. V26 stated that because she did not feel comfortable with transferring R3 by herself V13 showed her. V26 stated that she would never do that because R3 didn't stand and didn't help at all. V26 stated that V13 grabbed a hold of R3 in a bear hug and lifted her off the bed and down in the chair. V26 stated that the transfer was not smooth and R3 didn't move her feet. V26 stated that R3's feet did not move during the transfer. V26 stated that she is not sure if R3's leg hit anything or twisted. V26 stated that V13 just picked R3 up and put her in the chair.

On 2/5/2024 at 10:49 PM V13, CNA, stated that she provides care to R3. V13 stated that they changed R3's transfers. V13 stated that R3 was a 2 person transfer and now she is a lift. V13 stated that she doesn't know when it changed. V13 stated that she has in the past transferred R3 alone. V13 stated that she was out sick and is now returning. V13 stated that it's been about 2 weeks.

On 2/6/2024 at 10:48 AM R3 stated that her leg

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 02/09/2024

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 19	S9999		

got bent and twisted. R3 stated that it was dark. R3 stated that 2 girls came in and got her up. R3 stated that she was lifted and when they turned her, (R3), her leg got twisted and bent back. R3 stated that this caused her to sit down hard, and it hurt. R3 stated that it was a lot of pain when it happened and then less. R3 stated that she went to dialysis that day and it started hurting worse. R3 stated that she told the nurse and that she got Tylenol. R3 stated that it helped but the pain never went away. R3 stated that the pain never went away and that she was always in pain. R3 stated that she kept telling the staff. R3 stated that she would tell anyone she could because it hurt so bad. R3 stated that when they moved her it hurt worse. R3 stated that even though she told them they continued to transfer her without the lift. R3 stated that this caused more pain. R3 stated that she remembers her son in law coming to visit and then her daughters. R3 stated that they were supposed to use the lift and didn't. R3 stated that she told the nurse. R3 stated that she was in a lot of pain. R3 stated that she doesn't remember the day but knows it was before she went to dialysis. R3 stated that she told the nurse.

On 2/8/2024 at 9:00 AM V1, Administrator, stated that she was made aware of the incident the day before R3 wentout to the hospital. V1 stated that an investigation was performed. V1 stated that her findings were that 2 aides transferred R3 without using the mechanical lift. V1 stated that R3 did not complain of pain at that time. V1 stated that R3 started to complain of pain and was given pain medication. V1 stated that R3's pain continued, the doctor was notified, and x rays were ordered. V1 stated that the x ray technician did not come on initial day and was rescheduled for the following day. V1 stated that R3 continued to complain of pain and was sent

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 02/09/2024

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 20	S9999		

out to the hospital. V1 stated that she feels that the nurses did what needed to be done in this situation. V1 stated that they were able to identify the staff involved in the incident. V1 stated that the aides admitted to the transfer. V1 stated that V26 and V7 performed the transfer. V1 stated that V22 and V23 were on that shift as well. V1 stated that there has been some changes and staff have been terminated and in serving was performed on the mechanical lift.

The facility's Reporting of Unusual Occurrences Policy, effective date of 6/2015 and reviewed date of 9/2022, documents the purpose is to provide a process for the reporting and reviewing unusual occurrences. The Policy documents "4. The resident will be evaluated after the incident/occurrence to determine the injury. The evaluation that is done is based on the occurrence and documented in the EHR (Electronic Health Record). If the incident involves a visitor or staff, then a note is made and placed in a file for the Administrator. 5. The provider, as well as the family is notified of the incident." The Policy documents "9. The investigation for falls, skin tears and unknown injury will begin immediately and will be entered into the risk management portal."

(Same violation)