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 10/03/2023

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

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S 000	Initial Comments Facility Reported Incident of 7-12-2023/IL164740	S 000		
S9999	Final Observations Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.3210t) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to prevent sexual abuse by a male resident for 1 of 3 residents (R12) reviewed for abuse on the sample list of 27. This deficient practice resulted in R27 having inappropriate sexual contact with R12.	S9999		

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S9999	Continued From page 2 Findings include: R12's Care Plan, (CP), dated 12/5/2019, documents, ABUSE: (R12) is considered at risk for abuse/neglect due to, mood cognition, behavioral/physical deficits. She is noted to be social with other residents. It continues, address all complaints/concerns promptly with Grievance policy and procedure. Intervene if observing any conflict to avoid potential situations of abuse/neglect. Report any suspicion of abuse to the Administrator. Will complete/update risk, abuse/neglect assessment initially and prn, (as needed). 9/10/2020 The resident has, impaired cognitive function & impaired thought processes r/t, (related to), dementia. It also documents, 3/24/23 ADL, (activity of daily living), (R12) requires assist with daily care needs r/t impaired decision-making skills r/t mental illness and anti-psychotropic medications. (R12) has a diagnosis & history of severe mental illness (SMI)- Schizophrenia and Bipolar. (R12's) problems & symptoms are manifested by: Observable medical/psychiatric/ cognitive conditions that may require on-going assessment, consultation & intervention. Need for on-going psychoactive medication. Psychiatric diagnosis are Schizophrenia and Bipolar disorder. 5/13/22 (R12) was noted to consume a small amount of hand sanitizer without any adverse side effects R12's Minimum Data Set (MDS), dated 5/11/23 and 8/10/23, documents that R12 is severely cognitively impaired. The Facility-Reported Incident Form, not dated, documents, Name of resident Allegedly Abused or Neglected. (R12), BIMS, (Brief Interview for Mental Status), 2 (Severe Cognitive impact) Alert	S9999		

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S9999	Continued From page 3 and Oriented X1. Diagnosis Ataxia following Nontraumatic intracerebral Hemorrhage, Epilepsy unspecified, COPD, (Chronis Obstructive Pulmonary Disease), Schizoaffective disorder, Schizophrenia. It continues: name of resident/Alleged Perpetrator (R27), BIMS 15 Alert and Oriented x 4. Diagnosis Schizoaffective disorder, bipolar, essential hypertension, hyperlipidemia, hypothyroidism. Allegation type Sexual Abuse. Initial Report: September 17th at 8:55 PM it was reported that R27 was in R12's room and allegedly inappropriately touching R12 chest on top of R12's shirt. The Final Report documents, conclusion of investigation based on findings. R27 did enter the room and lay in bed next to R12. He immediately left once the other residents on the hall asked him to leave. R12 did call him into the room, because she thought he was her husband. No intent of sexual abuse was intended by R27. R27 was placed on 1:1, until his discharge the following day to (sister facility) during investigation of allegation for safety of all residents. An interview of the alleged perpetrator, not dated, documents, that R27 was going in R12's room to lay down with R12, because R12 was calling out to him and smiling. Then a lady saw him go in the room and yelled at R27 to get out, so R27 left the room. On 9/26/23 at 9:00 AM V4, LPN, stated, that she was the Nurse on duty the night of the incident. V4 stated, that (R1) and (R2) came to her and reported that they saw (R27) laying in (R12's) bed with his hands going up the front of her. V4 stated, that she was told that R1 watched R27 going down the hall and go into the room. V4 stated, that they followed him and yelled at him to	S9999		

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S9999	Continued From page 4	S9999		

get out. V4 stated, that she assessed R12. V4 stated, that when asking R12 about the situation R12 stated, that R12 thought R27 was her husband.

On 9/26/23 at 1:56 PM R1 stated, that she was at the Nurse's Station and saw R27 go pass her. R1 stated, that she saw R27 go from room to room going in and out of them. R1 stated, that when he got to (R12's) room he did not come out. R1 stated, that she told R2. R1 stated, that she and R2 went down to the room R1 stated. that R2 went in first to the room and opened the door. R1 stated, that R27 was lying in the bed with his hand going up the front of R12's shirt. R1 stated, that she and R2 started, yelling at R27 to get out of the room. R1 stated, that R27 did get up and left the room. R1 stated, that they then told V4.

R1's MDS, dated 8/21/23, documents, that R1 is cognitively intact.

On 9/26/23 at 2:15 PM R2 stated, that she was told by R1 that R27 had went into R12's room and had not come back out. R2 stated, at that point she and R1 went to R12's room. R2 stated that the door was closed. R2 stated, that she pushed the door open and R27 was laying on the bed with his hand going up and down R12's shirt. R2 stated, that she started yelling get out of here and R27 jumped up with his hands up, pants unzipped and his penis out. R2 stated, that R27 left the room and she and R1 told V4.

R2's MDS, dated 7/13/2023, documents, that R2 is cognitively intact.

On 9/26/2023 at 9:29/23 R12 stated, that she does not remember having a man in her bed. R12 stated, that she does not know who R27 is

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S9999	Continued From page 5	S9999		

and does not remember him touching her on her shirt her breast. R12 stated, that her husband has passed away. R12 stated, that she would not have invited R27 to lay in her bed. R12 stated, that she does not remember this happening, but would not have asked anyone to get in bed with her and touch her.

On 9/27/2023 at 9:30 AM R8 stated, that she was in the room when the male resident got into the bed with R12. R8 stated, that R12 has a loud voice, and she did not hear R12 invite R27 into the room. R8 stated, that she was able to see them in the bed. R8 stated, that she was unsure exactly what was going on, but could see R27 kissing R12's neck and R27's hand moving up and down on R12's chest. R8 stated, that she yelled at them to close the curtain and R27 told her to mind her own business.

R8's MDS, dated 7/19/2023, documents, that R8 is moderately impaired cognitively.

On 10/2/2023 at 1:20 PM V8, LPN, stated, that R8 is alert and oriented and able to make her needs known and answer questions appropriately.

On 9/28/23 at approximately 3:40 PM V1 stated, that she spoke with her Supervisors and was told that, because this was only witnessed by other residents it was not substantiated. When asked what was seen on the camera, V1 stated, that they were not able to see R27 walking on the hall or enter R12's room. V1 stated, that they were not able to see anything.

On 10/2/23 1:50pm V5, CNA, stated, that she is the primary CNA on R12's hall. V5 stated, that she has worked with R12 for a long while. V5

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S9999	Continued From page 6 stated, that she has not witnessed or heard of R12 inviting a man into her room and bed. The facility's Abuse Policy and Prevention Program 2022, not dated, documents, this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. This facility therefore this facility prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. Sexual Abuse includes, but not limited to, sexual harassment, sexual coercion, or sexual assault including non-consensual or non-competent sexual activity. (A)	S9999		