Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145655	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Woodriver	393 Edwardsville Road Wood River, IL 62095

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview, observation and record review, the facility failed to provide complete incontinent care to prevent urinary tract infections (UTIs) for 1 of 3 residents (R2) reviewed for incontinent care and UTIs in the sample of 4. Findings include: On 5/3/24 at 2:30 PM, incontinent care was observed on R2 with V9, CNA (Certified Nurse's Assistant), and V13, CNA. R2's incontinence brief was removed and was wet with urine. V9 donned gloves, got supplied ready, changed gloves, and did not perform hand hygiene. R2 was then turned onto her right side, V9 took a pre-packaged wipe and wiped down the buttocks towards the urethra, then down the left side and back up the left leg. V9 then took a clean wipe and wiped upwards in the buttock crease and placed a clean brief under R2. R2 was then turned onto her left side, R2's right side was not cleaned, and V13 then took and pulled the brief towards her, then R2 was turned onto her back. V9 then took a clean wipe and wiped down in-between the labia and then fastened R2's brief. R2's Face Sheet, undated, documents R2 has the following diagnoses: History of UTIs, Neuromuscular Dysfunction of the Bladder, Guillain Barre Syndrome and Need for Assistance with Personal Care. R2's Minimum Data Set (MDS), dated [DATE], documents R2 is dependent with toileting and incontinent of bowel and bladder. R2's Care Plan, dated 12/28/23, documents R2 requires assistance with Activities of Daily Living (ADL) care, is incontinent of bowel and bladder and requires total assistance with toileting. R2's Progress Note, dated 3/15/24 at 3:11 PM, documents the following: Resident sent out to the hospital. R2's Progress Note, dated 3/15/24 at 5:25 PM, documents the following: Resident admitted to the hospital with a diagnosis of UTI, Altered Mental Status and Pressure Injury. R2's Hospital After Visit Summary, dated 3/19/24, documents R2 was admitted with the following diagnoses: Acute Metabolic Encephalopathy, Seizure, UTI, and Sepsis. The urine culture was positive for E. Coli (Escherichia Coli). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Urine Culture, dated 3/22/24, documents R2's urine was positive for E. Coli. R2's Progress Note, dated 4/17/24 at 8:18 AM, documents the following: Patient unresponsive when trying to administer medications this morning, oxygen saturation 82%, diaphoretic, pulse 56, blood pressure 118/62, blood sugar 117. Applied oxygen at 2 liters per nasal cannula. Called EMS (Emergency Medical Services) to facility. R2's Hospital Post Acute Care Transfer Report, dated 4/21/24, documents R2 was diagnosed with the following: Fecal Impaction, Hypoxemia, and UTI. On 5/7/24 at 9:15 AM, V2, Director of Nurses (DON), stated she would expect staff to complete incontinent care on any incontinent resident. The Incontinence Care policy, dated 5/2015, documents the following: Incontinence care is provided to keep residents as dry, comfortable and odor free as possible. Clean perineal area with appropriate cleanser and dry. Cleansing should always be from front to back.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to have enough CNAs (Certified Nurses Assistants) working to meet the needs of the residents for 1 of 4 residents (R3) reviewed for staffing in the sample of 4. Findings include: On 5/3/24 at 6:15 AM, R3 stated she is continent of bowel and bladder if the staff get her on the bed pan. R3 stated during the night on 4/29/24, her call light had fallen off her bed and she couldn't reach it and her cell phone was not within her reach. R3 stated finally around 5:00 AM, she managed to get herself to the side of the bed and was able to reach her cell phone and called the facility and they sent V7, Certified Nursing Assistant, CNA, to her room. R3 stated she hadn't been checked on by staff all night and was soaked with urine. R3 stated when V7 entered her room, she (R3) asked V7 why she hadn't checked on her all night and V7 replied because they were short staffed and busy. R3 stated she was chaffed from lying in her urine all night but is cleared up now. R3's Minimum Data Set (MDS), dated [DATE], documents R3 has a BIMS (Brief Interview for Mental Status) score of 15, which indicates R3 is cognitively intact. On 5/3/24 at 5:45 AM, V4, Licensed Practical Nurse, LPN, stated they are short staffed on nights a lot due to call offs. V4 stated normally they have two nurses and four to five CNAs on night shift but there are times when there are just three and it's hard. V4 stated management offers to come in and help but doesn't come in until around 4:00 AM and by then the shift is almost over, so they work together to get stuff done. V4 stated she has seen residents lie in their urine/feces for long periods of time when they are short staffed. On 5/3/24 at 7:48 AM, V9, CNA, stated she worked night shift on 4/29/24 on the 400/500 halls and half of the 300-hall. V9 stated there were three CNAs working that night, there would have been four, but one called off and they couldn't find anyone to replace them. V9 stated she and another CNA worked the 300, 400 and 500 halls with no problems. V9 stated there was only one CNA for the 100/200 halls and she (V9) went and helped that CNA because one CNA couldn't do it on those halls by them self. On 5/3/24 at 12:15 PM, V10, CNA, stated they are short staffed with CNAs sometimes. V10 stated they don't have very many full-time staff that work in the building so they must use agency. On 5/7/24 at 9:15 AM, V2, Director of Nurses, DON, stated they staff their CNAs and nurses utilizing a staffing grid based on census. V2 stated with their census today of 77, they have 3 nurses on day shift, 3 nurses on evening shift, 2 nurses on night shift and between 21-22 CNAs in a 24-hour period. V2 stated if someone doesn't show up for their shift, they will reach out to them to try and find out why. If they call off for their shift, they will reach out to their own CNA staff and agency CNAs to see if someone can come into work. V2 stated the Restorative CNA and staffing director are both CNAs so they will come in or she (V2), the ADON (Assistant Director of Nurses) and the Wound Nurse will help the CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNA Schedule documents only 3 CNAs working the night shift on 4/16/24, 4/27/24, and 4/29/24. The facility was unable to provide a staffing policy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to ensure medications were given as ordered by the physician to 1 of 3 residents (R3) reviewed for pharmacy services in the sample of 4. Findings include: On 5/3/24 at 6:15 AM, R3 stated she was denied her medication, staff were giving her the run around and she ended up running out. R3 stated she was getting her medications delivered to her house through her own pharmacy before she came to the facility. R3 stated the nurses didn't let her know she was running low, so she ran out and then had to have them refilled. R3 stated she was without her medications for about 3 days. R3 stated she doesn't care about her vitamins but needs her pain medication, muscle spasm medication, heart medications and seizure medications. R3's Face Sheet, undated, documents R2 has the following diagnoses: Benign Intracranial Hypertension, Diabetes Mellitus, Epilepsy, Transient Cerebral Ischemic Attack, Hemiplegia, Hyperlipidemia, Hypertension, Atrial Fibrillation, Depression and Adjustment Disorder. R3's Minimum Data Set, MDS, dated [DATE], documents R3 has a Brief Interview of Mental Status, BIMS, score of 15, which indicates R3 is cognitively intact. R3's Physician Order Sheet (POS) documents the following orders: 3/11/24 - Baclofen 10 mg (milligrams) TID (three times daily); 2/17/24 - Trileptal 600 mg BID (twice daily); 2/17/24 - Amlodipine 10 mg Qd (daily); 2/17/24 - Atorvastatin 40 mg every evening; 2/18/24 - Jardiance 10 mg Qd (daily); 2/17/24 - Lamictal 25 mg two tablets BID and 100 mg Qd; 2/17/24 - Lisinopril 20 mg Qd; 2/19/24 - Venlafaxine 150 mg Qd and 75 mg Qd; 2/17/24 - Coreg 3.125 mg BID; Metformin 1000 mg BID. R3's Medication Administration Record (MAR), dated 3/2024, documents Trileptal was not given 9 times. R3's MAR, dated 4/2024, documents R3's Amlodipine was not given once; Atorvastatin was not given twice; Jardiance was not given once; Lamictal was not given once; Lisinopril was not given once; Coreg was not given 3 times; Metformin was not given 3 times; Trileptal was not given 8 times, Baclofen was not given 21 times. R3's MAR, dated 5/2024, documents R3's Baclofen was not given twice and the Trileptal was not given once. R3's Progress Note, dated 4/8/24 at 1:36 PM, documents the following: Spoke with pharmacy, Trileptal will be out for delivery tonight. R3's Progress Note, dated 4/8/24 at 6:32 PM, documents the following: Baclofen, awaiting pharmacy delivery. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Progress Note, dated 4/8/24 at 8:05 PM, documents the following: Baclofen, awaiting pharmacy delivery. R3's Progress Note, dated 4/26/24 at 9:58 AM, documents the following: Baclofen, awaiting delivery from pharmacy. R3's Progress Note, dated 4/26/24 at 4:38 PM, document the following: Baclofen, medication not available, see progress note. R3's Progress Note, dated 4/26/24 at 5:32 PM, documents the following: Baclofen not in facility. Resident receives medications from an outside Pharmacy. Called pharmacy, spoke with customer service representative and R3's Baclofen was not on her profile. This writer informed him that she would fax orders over. Per customer service representative, once medications are reviewed, will call facility for medications not on their profile to request scripts from the physician for those medications. R3's Progress Note, dated 5/2/24 at 8:38 AM, documents the following: Resident voiced displeasure of having her medications come from her pharmacy due to the difficulty in getting them here. Writer explained that she would talk to our pharmacy and get things switched over. She (R3) was agreeable to this. R3's Progress Note, dated 5/2/24 2:31 PM, documents the following: Spoke with pharmacy and confirmed dispense dates. Resident medications Baclofen and Venlafaxine will be sent out tonight as a 10-day supply. All of her medications will be sent on the 11th from our pharmacy for routine fill. On 5/7/24 at 9:15 AM, V2, Director of Nursing, DON, stated when a medication is not available, the nurse is to call pharmacy, see what the hang up is, various things impact why a medication isn't available and then they try to resolve it. When the nurses are documenting #9 on the MAR, it means the medication was not given or not available and then allows for the nurse to make a progress note as to why it wasn't given. The Medication Administration policy, dated 6/2015, documents the following: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. If a medication is ordered but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available, obtain it from the contingency or convenience box. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's record.