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	10/17/2024

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49494

Based on observation, interview, and record review the facility failed to prevent pressure ulcer development and failed to provide resident centered interventions, monitoring and orders for residents who were identified to be at risk for pressure ulcers and for residents with pressure ulcers for 2 of 3 residents (R1, R2) reviewed for skin impairment. This failure resulted in R1 acquiring an unstageable pressure ulcer to his/her left heel and stage 3 pressure ulcer to right buttock; R2 requiring debridement of an unstagable pressure ulcer during a hosptial stay to R2's coccyx.

Findings include:

1. R1's face sheet with a print date of 10/21/2024 documented R1 has diagnoses of type 2 diabetes mellitus, sepsis, cognitive communication deficit, contracture of left knee, dementia, osteoarthritis, hypertension, and paroxysmal atrial fibrillation.

R1's MDS (Minimum Data Set) dated 10/9/24 documented R1 has moderately impaired cognition.

R1's MDS dated [DATE] documented R1 requires substantial to maximal assistance with bed mobility and is dependent on staff for all other mobility.

R1's care plan, undated, documented R1 is at risk for pressure ulcers related to impaired mobility and incontinence. This care plan documented R1's interventions include assist and encourage resident to turn and reposition frequently, document signs and symptoms of skin break down, low air loss mattress, notify nurse of signs and symptoms of skin breakdown noted during routine care, weekly and prn (as needed) skin assessment.

R1's progress note dated 8/30/24 at 10:40 AM by V10 NP (Nurse Practitioner) documented R1 developed a new stage 2 pressure ulcer to left heel. V10 documented wound size 2.5 cm x 4 cm x 0 cm, wound base 100% epithelial, wound edges attached, and exposed tissues: epithelium and dermis.

R1's progress note dated 9/5/24 at 9:17 am by V10 NP documented wound left heel, primary etiology: pressure, stage/severity: stage 2, wound status: worsening, size 3 cm x 5 cm x 0 cm, wound base: 100% eschar.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
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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 0686 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 9/12/24 at 10:10 AM by V10 NP documented R1's stage 2 pressure ulcer on left heel as worsening and new measurements of 4.6 cm x 4.5 cm x 0 cm. This progress note documented that R1 was experiencing pain in the heel at rest and that V10 surgically debrided that pressure ulcer during this visit. V10 documented post-debridement measurement of 4.6 cm x 4.5 cm x 0 cm. R1's progress noted dated 9/20/24 at 9:40 am by V10 NP documented R1's stage 2 pressure ulcer on left heel as unstageable. On 10/17/24 at 8:35 am R1 was observed in bed on a regular mattress lying on his back. On 10/17/24 at 11:35 am V8 LPN (Licensed Practical Nurse)/Wound Nurse and V9 LPN/former Wound Nurse were observed as they performed wound care to R1's heel. V9 stated R1's heel started out as what appeared as a bruise and that the pressure ulcer worsened and developed tunneling in the wound. V9 stated she would consider the pressure ulcer on R1's heel to be a stage 4 since it has the tunneling but she must document what the Nurse Practitioner stages the wound as, so she documented a stage 2 on the EMR (Electronic Medical Record) wound evaluation with a picture dated 9/12/24 at 3:07 pm. V9 stated that R1 is supposed to be on a low air loss mattress and she doesn't know why he isn't unless it didn't get moved when he changed rooms about a week ago. V9 stated that R1's only pressure ulcer is on R1's left heel and that R1 does not have any pressure ulcers on his backside. Surveyor then requested to observe R1's buttock region. V8 and V9 then turned R1 onto his right side revealing a large undated dressing covering R1's coccyx and partially covering R1's left buttock. V9 stated to V8 he has a wound on his bottom and a dressing over it. V8 replied no one told me. V9 then removed the dressing from R1's buttock/coccyx region revealing a large area of detached skin approximately 6 cm x 6 cm on left buttocks from what appeared to have been a fluid filled blister that had drained and an approximate 1 cm x 1 cm open area to R1's coccyx. V9 stated that R1's EMR does not document anything regarding these open areas to R1's buttock and coccyx. V9 stated that R1 does not have a treatment order for these wounds and that she would have expected the nurse to notify R1's doctor about the new pressure ulcers and get orders for a treatment. V9 stated that she expects the staff to turn and reposition R1 at least every two hours. On 10/17/24 at 11:55 am R1 stated that the staff do not turn him very often and that he was on his back all morning until the nurses changed his dressing. R1's progress note dated 10/17/24 with time of service at 12:14 pm V10 NP documented left heel stage 3 pressure ulcer, right buttock new stage 2 pressure ulcer 6 cm x 6.1 cm, and coccyx new DTI (deep tissue injury) with primary etiology as pressure measuring 1 cm x 0.6 cm. R1's progress notes orders do not documented anything regarding the pressure wounds on R1's buttock and coccyx region until V8 and V9 discovered the wounds upon the surveyor's request to observe R1's skin on R1's buttock region. R1's TAR (Treatment Administration Record) documented a new order to cleanse buttock with wound cleanser, apply calcium alginate, collagen, Silvadene, cover with bordered gauze everyday shift to promote wound healing dated 10/18/24. This treatment is not signed off as completed on 10/20/24 as ordered. R1's TAR documented an order to apply calcium alginate, collagen, Silvadene, and rolled gauze to R1's left heel daily dated 10/17/24. This treatment is not signed off as completed on 10/20/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/21/24 at 11:32 AM V2 DON (Director of Nursing) stated that she would have expected the nurse that placed the dressing on R1 to call R1's doctor and get a treatment for the pressure ulcers that were found but were not documented on R1's coccyx and buttock. V2 stated that she would have expected R1 to be on a low air loss mattress as is on his care plan. On 10/21/24 at 3:45 pm V1 Administrator stated that she would expect interventions to be in place as care planned and that R1 should have been on a low air loss mattress. V1 stated that if a treatment is not signed off on the TAR, then it was not completed as ordered. 2. R2's face sheet with a print date of 10/21/24 documented R2 has diagnoses of metabolic encephalopathy, type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema, diabetic neuropathy, dysphagia following cerebral infarction, depression, schizoaffective disorder, delusional disorders, dementia, cerebrovascular disease, Alzheimer's disease with early onset, hypertension, atherosclerotic heart disease, and chronic kidney disease. R2's MDS dated [DATE] documented R2 is severely cognitively impaired and is dependent on staff for bed mobility. R2's progress note dated 8/9/24 at 11:30 AM documented R2 has a new skin condition. Please see skin condition observation for details. R2's skin condition report dated 8/9/24 at 12:06 PM documented left buttocks open area, Kennedy ulcer in appearance. R2's skin and wound progress note dated 8/22/24 at 9:55 AM by NP V10 documented reason for visit: new skin and wound consult on current resident. It continues, wound assessment: Wound 1, location: coccyx, primary etiology: pressure, stage/severity: unstageable, wound status: new. R2's skin and wound progress note dated 9/5/24 at 8:16 AM by NP V10 documented wound 1, location: coccyx, primary etiology: pressure, stage/severity: unstageable. It continues, wound 2, location: right heel, primary etiology: pressure, stage/severity: DTI (deep tissue injury), size 1.5 cm x 2 cm x 0 cm. It continues, wound #2 right heel pressure treatment recommendations: 1. Cleanse with wound cleanser. 2. Apply skin prep to base of the wound. 3. Leave open to air. 4. Daily treatment. R2's skin and wound progress note dated 9/16/24 at 2:41 PM by NP V10 documented wound 1, location: coccyx, primary etiology: pressure, stage/severity: unstageable, size: 1.5 cm x 3 cm x 0.5 cm, wound status: stable. It continues, wound 2, location: right heel, primary etiology: pressure, stage/severity: DTI (deep tissue injury, size 1.5 cm x 2 cm x 0 cm. R2's skin and wound progress note dated 10/3/24 at 8:47 AM by NP V10 documented wound 1, location: coccyx, size 1.5 cm x 2.6 cm x 0.7 cm. Undermining from 12 o'clock to 1 o'clock, 3 cm. It continues, wound #1 coccyx pressure treatment recommendations: 1. Cleanse with wound cleanser. 2. Apply Dakins moistened fluffed gauze to base of the wound. 3. Secure the bordered gauze. 4. Change daily, and PRN (as needed). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's skin and wound progress note dated 10/11/24 at 11:12 AM by NP V10 documented wound 1, location: coccyx, primary etiology: pressure, stage/severity: unstageable, size 3 cm x 3.2 cm x 0.7 cm, undermining from 10 o'clock to 3 o'clock. It continues, wound 2, location: right heel, primary etiology: pressure, stage/severity: stage 3, wound status: worsening, size: 0.5 cm x 0.3 cm x 0.1 cm. R2's TAR dated October 2024 documented a treatment order for R2's coccyx to cleanse with wound cleanser and apply Dakins moistened fluffed gauze everyday and night shift for wound care management. R2's October 2024 TAR does not document that this treatment was performed as ordered on the following day shifts: 10/4/24, 10/5/24, and 10/9/24. R2's TAR dated October 2024 documented a treatment order to R2's right heel to be cleansed with wound cleanser and to apply skin prep everyday shift for wound care management. R2's October 2024 does not document that this treatment was completed on 10/2/24, 10/4/24, and on 10/5/24 as ordered by R2's physician and as recommended by V10 NP for wound consultant company. R2's wound progress notes by NP V10 were reviewed and none of the progress notes by V10 documented a diagnosis of a Kennedy ulcer on R2's coccyx. R2's EMR does not document a diagnosis of a Kennedy ulcer by a Physician nor by a Nurse Practitioner. R2's progress note dated 10/12/24 at 1:20 PM documented that R2 was transferred to a local hospital. R2's hospital progress note dated 10/16/24 at 7:33 PM documented Plan #3. Left buttock decubitus ulcer. This is a deep ulcer. Doctor V15 has debrided it. Wet to dry dressing should be continued and the patient will need frequent repositioning. R2's hospital records were reviewed, and these records do not document that R2's pressure ulcer is a Kennedy ulcer. On 10/17/24 at 12:06 PM V9 stated that R2's pressure ulcer looked like it was the start of a Kennedy ulcer when it started and that is what she documented on R2's wound evaluation form. On 10/21/24 at 11:32 AM V2 DON stated that she is not sure where R2's diagnosis on a Kennedy ulcer came from. The facility's Skin Management: Monitoring of Wounds and Documentation policy dated 1/2022 documented it is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. Responsible Party: All nursing staff. General Guidelines: An evaluation of the PU/PI (pressure ulcer/pressure injury), in no dressing is present; an evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking); the status of the area surround the PU/PI; the presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection; and whether pain, if present, is being adequately controlled. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Skin Management: Pressure Injury Treatment/General Wound Treatment Policy dated 6/2015 documented General: The following treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used. It continues, an order is required for all treatment orders. Responsible Party: All nursing staff. General Guidelines: implement prevention protocol according to resident needs, sensory perception risk factor: watch for nonverbal cues, assess areas of the body that do not feel pain for openings or redness, Moisture: avoid prolonged periods of wetness, apply moisture barrier with each incontinent episode, choose treatments that do not cause skin maceration, Activity: turn and reposition as needed using a person-centered approach (minimum of every 2 hours). It continues 10. The staff nurse will notify the Wound Nurse upon identification of skin impairment. If the Wound Nurse is not available, the staff nurse should document the open area on a skin screen form and alert the health care provider for treatment orders.