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	03/04/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed assess, monitor, and treat a change of condition for 1 of 4 resident (R6) reviewed for quality of care in the sample of 15. This failure resulted in a delay of treatment for a significant change in condition resulting in R6's hospitalization . Findings include: R6's Face Sheet, print date of 2/19/25, documents that R6 was admitted on [DATE] and has diagnoses of Alzheimer's Disease and Dementia. R6's Minimum Data Set, dated dated [DATE], documents that R6 is moderately cognitively impaired and is independent with eating. R6's Nurses Note, dated 1/13/25, documents, Resident returned to the facility via (hospital) ambulance accompanied by EMS (Emergency Medical Services). The resident is alert and denies pain. The resident was a total assist into her bed and is 1.5 L (liters) of oxygen per nasal canula. Call light is within her reach. The resident is on droplet / contact isolation for influenza. R6's Nurses Note, dated 1/14/25, documents, Resident refused to leave O2 NC (oxygen) (nasal canula) on, repeatedly attempted to place NC on and resident takes it off. Resident educated on the importance of using her supplemental oxygen and resident still refuses. R6's Nurses Note, dated 1/15/25, documents, 'Resident refuses to keep on O2. Resident has been redirected several times. Resident is currently sitting in bed resting with nasal canal (cannula) on will continue to monitor. R6's Note Text, dated 1/15/25 9:53 PM, documents R6 received a DRIPT IV Therapy infusion per provider order with post infusion vital signs of 136/84 blood pressure and a heart rate of 82. R6's Progress Note, written by V12, Medical Nurse Practitioner, dated 1/17/25, documents, Patient seen and examined today for routine 30 day follow up. Patient reports good appetite. Is sleeping well overnight. Denies acute medical conditions. It continues, resident requires assistance with ADL's (activities of daily living) and mobility. Patient recently hospitalized for Influenza A. Continues to refuse to wear supplemental oxygen. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R6's vital signs, dated 1/18/25, documents R6's blood pressure of 102/68, heart rate of 51, temperature of 98. 2, respirations of 18, and oxygen saturation of 88%. R6's Meal Intake, dated 1/23/25, documents R6 at 75 to 100% of her meal at 11:15 AM and 12:45 PM. R6 has no other meal intakes documented before R6's discharge to the hospital on 1/27/25. The facility Weekly Weeks documents the week of 1/13 R6 weighed 173 pounds, the week of 1/20 R6 weighed 162.5 pounds. The facility Communication for Daily Facility Discharges documents R6 was sent to the hospital on 1/27/25 because of AMS (Altered Mental Status), Hypotension, and Dehydration. R6's Electronic Medical Record fails to document any other Nursing Notes, Vital Signs, Nursing Assessments, Doctor Notification, Change of Condition, or Hospital Transfer documentation between 1/13/25 and 1/27/25. R6's Emergency Department Disposition, dated 1/27/25, documents Hospital Problems present upon admission Pneumonia of right lower lobe, Acute on chronic hypoxic respiratory failure, Hypernatremia, Moderate malnutrition, SIRS (systemic inflammatory response syndrome) UTI (urinary tract infection). A/P (assessment and plan): lab's significant for leukocytosis 14.6, lab's look like hemo-concentrate. Hypernatremia 155 (high normal is 145) AKI (acute kidney injury), cre (creatine) 1.94 baseline 1.1, UA (urinalysis) showed 4 plus leukocyte estrase, 4 plus bacteria. CXR (chest x-ray) noted opacities right lower lobe concern for pneumonia, no pleural effusion, no pneumothorax. In the ED (Emergency Department), she was given ceftriaxone/azithromycin for pneumonia and UTI. 1 L of fluid and continuous fluid. Plan: Hypernatremia AKI cre 1.94 baseline 1.1 Free water deficit: 2.7 L. repeat labs, sodium q6h (every 6 hours) These fluid and electrolyte abnormalities are being treated, evaluated, or monitored. Dehydration - IVF's (Intravenous Fluids) and repeat electrolytes. On 2/20/25 at 11:43 AM, V2, Director of Nurses, stated, (R6) just came off of our NAR (Nutrition At Risk) watch on 1/6/25. The way that the weekly weights work is as long as the weight is done that week, I enter the weight on Friday, and then on Tuesday when the Dietitian comes, we talk about putting new interventions in place. (R6) was 173 the week of 1/13/25 and the week of 1/20/25 she was 162.5. I entered the (R6's) weight of 162.5 on the 24th which was a Friday. I had planned on talking to the Dietitian about her on Tuesday, but she was sent to the hospital on Monday (1/27/25) and did not return. We already had her on fortified pudding and supplements. We can put things in place but if she is not eating it is not going to help. I am not sure if the Doctor was notified of (R6) not eating. I did educate the staff to push fluids and encourage her to eat. The staff should have been charting on her decline, a note about her going to the hospital, meal intake, and notifying the doctor if they did. On 2/20/25 at 1:48 PM, V12, Medical Nurse Practitioner, stated, I saw (R6) on 1/17/25. I knew she had just come back from the hospital with Influenza. I was not notified that she had a decline, she was not eating, and had weight loss. I should have been. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/19/25 at 12:30 PM, V3, Assistant Director of Nurses, stated I took care of (R6) on 1/26/25 going into the 27th. I did hear she was not feeling well, wasn't eating, and didn't want to get her hair cut. She hadn't been herself after she came back from the hospital with the flu. She was not eating or drinking like before. She would go to the dining room for meals. Before she was independent with dining, after that sometimes we would have to help her and encourage her to eat. There should be nurse's notes of her decline and why when she was transferred to the hospital. On 2/19/25 at 2:30 PM, V16, Licensed Practical Nurse (LPN) stated R6 really did decline fast after she got the flu. On 2/19/25 at 2:45 PM, V17, Certified Nurse Aide (CNA), stated The last two weeks she was probably eating 25% of her meal. It came to where we had to feed her. She used to be able to eat. I would say she totally stopped eating 2 to 3 days before she went to the hospital. The nurses knew. It should be documented in our charting of the intakes. On 2/20/25 at 11:00 AM, V1, Administrator, stated that V24, agency LPN is the nurse that sent R6 out to the hospital. On 2/20/25 at 11:05 AM, V2, Director of Nurses, stated I was in the building the evening that (R6) went out to the hospital because I told (V24) to send her out. The aides came out and said that (R6) wasn't acting right. She was acting very sluggish just not herself. She had low blood pressure. On 2/20/25 at 11:07 AM, V22, CNA, stated, The last time I worked with her (R6) it was 2 days before she went out. She was really tired. I was able to get her eat a few bites. I had to fed her. I even tried to get her to take some bites of her fortified pudding, but she wasn't having it. She was ok just really really tired. She was still urinating like normal. I did chart her intakes. I let the nurse know that she did not have an appetite that day. On 2/20/25 at 11:39 AM, V24 stated, I haven't worked there often but I didn't send anyone out to the hospital while I was there. On 2/20/25 at 12:26 PM, V25, CNA, stated, I took care of (R6) the evening before she went to the hospital (1/26/25). Before she would talk to me. She was confused but she would talk. The last night I cared for her, she was completely out of it. She looked horrible. She would go ew ew ew she couldn't even talk anymore. I tried to get her to drink her water, but she couldn't even swallow it just sat in her mouth. The nurse was going in and giving her meds (medications). I asked what was going on and she said she has had a decline. On 2/20/25 at 1:20 PM, V8, Registered Nurse, stated, (R6) was more tired and less talkative but about her normal self. She would always sit in her doorway in her wheelchair wanting to go to her room which she was in her room. She wasn't doing that. As far as I know, she was eating and drinking just fine. I did not see anything alarming about her. The policy Change in Resident Condition, dated 9/2024, documents, Nursing will notify the resident's physician or nurse practitioner when: b. There is a significant change in the resident's physical, mental or emotional status. c. There is a pattern of refusing treatment or medication. It continues, e. It is deemed necessary or appropriate in the best interest of the resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Weight Change Policy, dated 9/22, documents, 1. Review weights and vitals dashboard for significant weight changes. 2. upon identification of a newly significant weight change, complete NARs weekly review tool. 3. Notify Dietician, Physician, and resident representative. The Policy Documentation by Exception, dated 9/2024, documents, 2. documentation should include any unusual event or change of condition of the resident. 3. Any communication with the physician, nurse practitioner, or consulting physician should be documented.

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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** 33112 Based on observation, interview, and record review, the facility failed to identify, assess, and monitor pressure ulcers, and provide the Physician prescribed treatment for 4 of 5 residents (R1, R2, R4, R5) reviewed for pressure ulcers in the sample of 15. The failure resulted in R5 developing a pressure ulcer of unknown stage while at the facility, not receiving treatment for a pressure ulcer for 23 days at which time it was unstageable, and R4 developing 3 pressure ulcers while at the facility and a sacral pressure ulcer that became infected. Findings include: 1. R5's Face Sheet, print date of 2/20/25, documents R5 was admitted on [DATE] with diagnoses of Severe Protein Calorie Malnutrition, Delusional disorder, Schizophrenia, and Heart Failure. R5's Minimum Data Set (MDS), dated [DATE], documents R5 is moderately cognitively impaired, dependent on staff for dressing, toileting, and hygiene, frequently incontinent for urine and bowel, and R5 has 2 unstageable pressure ulcers. R5's Braden Scale for predicting Pressure Sore Risk, dated 1/8/25, documents that R5 is a high risk for pressure ulcers. R5's Electronic Medical Record fails to document a Braden Scale before 1/8/25. R5's Nurse's Note, dated 12/1/2024 11:12 AM, documents, Resident has 2 open wounds. 1 is on his right hip, and the other is on his inner left knee. I put TAO (Triple Antibiotic Ointment) and bandages on both of the wounds. His right heel on the left side is also becoming soft. I had CNA (Certified Nurse Assistant) put a pillow in between his knees and feet to take the pressure off. Plan of care ongoing. R5's Weekly Skin Assessments, dated 11/14/24 - 12/23/24 fails to document any pressure areas noted on R5. R5's Electronic Medical Record fails to document a pressure ulcer wound assessment for the pressure ulcer found on 12/1/24, Physician Notification, or Physician Orders for treatment for the pressure ulcer. There are no progress notes regarding the monitoring, assessment, or treatment of R5's pressure ulcer from 12/1/24 to 12/24/24 for the pressure ulcer to R5's right hip. R5's Nurse's Note, dated 12/24/24, documents, Was informed by CNA (Certified Nurse Aide) that resident has a bad wound on his right hip/ butt. Check wound with wound NP (Nurse Practitioner) and found an unstageable wound. Resident stated that its fine don't touch it. Resident stated that it is not a wound, its clothing. Did wound care on wound with resident upset with wound care being done. Resident stated that he would pull it off when I am gone. R5's Treatment Administration Record (TAR) for December 2024, documents, Start date 12/19/24 Discontinue date of 1/5/25, right buttock, cleanse wound with wound cleaner and apply Silvadene, calcium alginate, collagen and cover with gauze dressing. every day shift for wound care. This TAR documents R5 refused dressing changes 5 of the 24 ordered changes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5's Skin and Wound Note, dated 12/24/24, documents, Patient seen today for a new unstageable PI (Pressure Injury) to his right hip. Per staff, patient refuses to roll to left side, always laying on right side causing pressure. Wound: 3 Location: Right hip Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: New. Size: 5.5 cm (centimeters) x 3 cm x 0.2 cm. Wound Base: 100% eschar Wound Edges: Attached Periwound: Intact, Fragile Exposed Tissues: Epithelium Exudate: None amount of None. Wound # 3 Right hip Pressure. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Hydrogel to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN (as needed). NEW RECOMMENDATIONS: The resident has a treatment change listed above. Please reference the recommended orders for updated treatments. R5's December 2024 Physician Orders or TAR failed to document a right hip pressure ulcer treatment recommendation, written on 12/24/24 of cleanse with wound cleanser, apply hydrogel to base of the wound, secure with bordered gauze, change daily and PRN (as needed). R5's Skin and Wound Note, 1/3/25, documents, Wound: 3 Location: Right hip Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Improving with delayed wound closure Size: 4 cm x 4 cm x 0.2 cm. Wound Base: 100% eschar Exposed Tissues: Epithelium Wound Edges: Attached Periwound: Intact, Fragile Exudate: None amount of None. Wound # 3 Right hip Pressure. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Hydrogel to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN. NEW RECOMMENDATIONS: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The resident has a treatment change listed above. Please reference the recommended orders for updated treatments. R5's January 2025 TAR, documents, Start date of 1/6/25 Discontinue date of 1/16/25, right buttock, cleanse wound with wound cleanser cover with hydrogel cover with boarder dressing every shift for wound care. This TAR documents that R5 refused 1 of the 10 dressing changes. R5's January 2025 TAR documents, right buttock cleanse wound with betadine and cover slough with silver alginate cover with boarder dressing every day shift for wound care. Start date of 1/17/25 Discontinue date of 2/4/25. This TAR documents that R5 refused the dressing change 2 of the 11 dressing changes. R5's January 2025 TAR documents, left hip clean with wound cleanser cover with silver alginate cover with boarder dressing every day shift for wound care. Start date of 1/17/25 Discontinue date of 2/4/25. 2. R4's Face Sheet, print date of 2/10/25, documents R4 was admitted on [DATE] with a diagnosis of compression fracture of T (thoracic) 11-T12. R4's MDS, dated [DATE], document that R4 was cognitively intact, required moderate to partial assistance for bed mobility, and totally dependent on staff for transfers, and was frequently incontinent of bowel. R4's Braden Pressure Ulcer Risk, dated 1/2/24 documents R4 is a high pressure risk. R4's Skin Condition Assessment, dated 1/2/25, fails to document a skin condition or pressure ulcer. R4's Electronic Medical Record fails to document an Admission Assessment for R4 on 1/2/25. R4's Physician Order, dated 1/3/25, documents Cleanse sacrum with wound cleanser &/or NS (normal saline), apply dry dressing daily until wound MD (Medical Doctor) sees for new ordered. R4's TAR, dated 1/3/25, documents Cleanse sacrum with wound cleanser &/or NS (normal saline), apply dry dressing daily until wound MD (Medical Doctor) sees for new ordered. R4's TAR, dated 1/3/25, documents apply zinc oxide to buttocks every shift for redness and open area. R4's Nurses Note, dated 1/5/25, documents, called to resident room, resident is not responding to verbal or physical stimulation, breathing normally, vital signs at this time 99.7, 68/48, 129 hr (heart rate), 22 resp (respirations). It continues, Call placed to 911 for transport to hospital for eval (evaluation) and treatment. R4's Nurse's Note, dated 1/9/25, documents, Resident came from (local hospital). It continues, Resident has an open wound on her bottom, hospital said wound was not open; however, the area is open. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Nursing Admission Observation, dated 1/9/25, documents R4 has Pressure Ulcers. This document fails to document the location, appearance, or measurements of the pressure ulcer (s). R4's Skin Note, dated 1/9/25, documents, No new skin issues noted. R4's Physician Order, dated 1/9/25, documents Apply Zinc Oxide to buttocks every shift for redness, open area. R4's TAR, start date of 1/9/25 end date of 2/5/25, documents apply zinc oxide to buttocks every shift for redness and open area. R4's Skin and Wound Evaluation, dated 1/10/25, documents, Wound Measurements Length 3.4 cm Width 1. 1 cm. This Skin and Wound Evaluation fails to document the type of wound, location, appearance of the wound, or notification of the Physician of the wound. R4's Skin Screen dated 1/9/25 and 1/16/25 fails to document R5 having skin conditions or pressure ulcers. R4's Skin and Wound Note, dated 1/15/25, documents Wound: 1 Location: right buttock Primary Etiology: Pressure Stage/Severity: DTI (Deep Tissue Injury) Wound Status: Present on Admission Size: 3 cm x 5 cm x 0 cm. Wound: 2 Location: sacrum Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Present on Admission Size: 4.5 cm x 2 cm x 0.2 cm. Wound Base: 10% granulation, 90% slough Wound Edges: Attached Periwound: Fragile, Erythema Exudate: Scant amount of Serous Wound: 3 Location: left buttock Primary Etiology: Pressure Stage/Severity: DTI Wound Status: Present on Admission Size: 7.5 cm x 4 cm x 0 cm. Wound Base: 100% epithelial Wound Edges: Attached Periwound: Intact, Fragile PLAN: Wound # 1 right buttock Pressure. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Zinc Oxide Paste to base of the wound. 3. secure with Leave open to air. 4. change Q Shift. Wound # 2 sacrum Pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Medical grade honey to base of the wound. 3. secure with Bordered gauze. 4. change Daily. Wound # 3 left buttock Pressure. Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Zinc Oxide Paste to base of the wound. 3. secure with Leave open to air. 4.change Q Shift. The above dressing(s) was selected to promote autolytic debridement and moist wound healing within the wound bed. R4's Physician Order, dated 1/17/25, documents sacrum clean with wound cleanser cover open wound with medihoney cover with sacrum comfort foam dressing every day shift for wound care management. R4's TAR documents, Start date of 1/17/5 Discontinue date of 2/4/25, clean with wound cleanser cover open wound with medihoney cover with sacrum comfort foam dressing every day shift for wound care management. R4's TAR, start date of 1/9/25 end date of 2/5/25, documents apply zinc oxide to buttocks every shift for redness and open area. R4's Skin and Wound note, dated 1/21/25 WOUND ASSESSMENT: Wound: 1 Location: right buttock Primary Etiology: Pressure Stage/Severity: DTI Wound Status: Worsening Size: 5 cm x 5 cm x 0 cm. Wound Base: 100% epithelial Wound Edges: Attached Periwound: Fragile Wound Pain at Rest: 5 Wound: 2 Location: sacrum Primary Etiology: Pressure Stage/Severity: Unstageable Wound Status: Improving without complications Size: 4.1 cm x 2 cm x 0.4 cm. Wound Base: 30% granulation, 70% slough Wound Edges: Attached Periwound: Fragile, Erythema Exudate: Scant amount of Serous Wound Pain at Rest: 5 Wound: 3 Location: left buttock Primary Etiology: Pressure Stage/Severity: DTI Wound Status: Improving without complications Size: 6.5 cm x 3 cm x 0 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound Base: 100% epithelial Wound Edges: Attached Periwound: Intact, Fragile Exudate: None amount of None. R4's Skin and Wound Note, dated 1/28/25 documents WOUND ASSESSMENT: Wound: 1 Location: right buttock Primary Etiology: Pressure Ulcer/Injury Stage/Severity: Stage 2 Wound Status: Improving without complications. Size: 4 cm x 2.5 cm x 0 cm. Wound Base: 100% epithelial Wound Edges: Attached Periwound: Fragile Exudate: Scant amount of Serosanguineous Wound Pain at Rest: 5. Wound: 2 Location: sacrum Primary Etiology: Pressure Ulcer/Injury Stage/Severity: Stage 4 Wound Status: Worsening Size: 3.8 cm x 3.5 cm x 0.5 cm. Wound Base: 60% granulation, 40% slough Wound Edges: Unattached Periwound: Fragile, Erythema Exposed Tissues: Muscle/Fascia, Subcutaneous, Dermis Exudate: Heavy amount of Purulent, Serosanguineous. Wound: 3 Location: left buttock Primary Etiology: Pressure Stage/Severity: Stage 2 Wound Status: Improving without complications Size: 2 cm x 1 cm x 0.1 cm. Wound Base: 100% epithelial Wound Edges: Attached Periwound: Intact, Fragile Exudate: Scant amount of Serosanguineous Wound Pain at Rest: 5 PLAN: Wound # 2 sacrum Pressure Ulcer/Injury Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Silver alginate to base of the wound. 3. secure with Bordered gauze. 4. change Daily. R4's 1/2025 Physician Orders or TAR fails to document R4 being ordered or treated the change in sacrum pressure ulcer treatment of cleanse with wound cleanser, apply silver alginate to base of wound, secure with bordered gauze, and change daily that was ordered on 1/28/25. R4's Emergency Department document, dated 2/3/24 4:07 PM, documents Was called into the room by (Hospital Registered Nurse) when changing the patient's diaper, she has a deep sacral ulcer with purulent drainage present. (Hospital Physician) updated on wound and CT (computed tomography scan) abdomen and pelvis, sed (sedimentation) rate, CRP (C- Reactive Protein), vancomycin, and cefepime ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Emergency Department Record, dated 2/3/25, documents Wound of sacral region initial encounter, Mental status has improved. Son at beside. Explained the wound will likely not heal at all given the advancement and bone involvement If there is any chance to heal this will require a diverting ostomy. Risks/benefits discussed. Code status has been addressed. Discussions with palliative hospice ongoing. As soon as determination is made, we can discuss further. R4's Hospital Record, dated 2/3/25, documents Sacral wound with infection, present on admission, s/p (symptom / plan) debridement. -Wound present on prior discharge but has certainly progressed and now with concerns of infection. - CT 5.8 x 1.6 x 2cm sacral ulceration extending from S (sacral)4-S6 containing gas and fluid and/or debris. Thin tract of gas along left side of sacrum with possible fistula and/or osteomyelitis - General surgery consulted - Continue Vanc (vancomycin)/Cefepime/Flagyl - Wound would likely require diverting ostomy for optimal healing - 2/5: Family opting to proceed with surgical intervention and hospice will follow for discussion postoperatively - 2/6: general surgery for sacral debridement and possible diverting ostomy - Wound culture with MSSA (Methicillin- resistant staphylococcus aureus), pseudomonas, continue vanc/cefepime/flagyl today. can likely de-escalate postoperatively pending findings. 3. R1's Face Sheet, print date of 2/10/25, documents R1 was readmitted on [DATE] and has diagnoses of Type 2 Diabetes Mellitus and Dementia. R1's MDS, dated [DATE], documents that R1 is mildly cognitively impaired, requires substantial maximal assist with rolling in bed, dependent on staff for transfers, has an indwelling urinary catheter, and is always incontinent of bowel. R1's Skin and Wound Note, dated 2/5/25, documents Patient seen today for a healing stage 4 PI to his right buttock. Location: right buttock Primary Etiology: Pressure Stage/Severity: Stage 4 Wound Status: Stable Size: 0.8 cm x 0.5 cm x 0.2 cm. Wound Base: 70% epithelial, 30% granulation, 0% slough, 0% eschar. Wound # 5 right buttock Pressure Treatment Recommendations: 1. Cleanse with wound cleanser. 2. apply Collagen Particles to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN. NEW RECOMMENDATIONS: The resident has a treatment change listed above. Please reference the recommended orders for updated treatments 2/5. (continued on next page)

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	03/04/2025

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/8/25 at 9:18 AM, V4, Certified Nurse's Aide (CNA) and V5, CNA, entered R1's room to provide incontinent care. V4 removed R1's covers. R1 is not wearing heel protectors. R1 had a large liquid bowel movement that has leaked out of R1's incontinent brief. R1's brief was removed. V4 provided incontinent care. R1 did not have a dressing on the right buttock pressure ulcer. V4 confirmed R1 did not have a pressure ulcer dressing on the right buttock. The pressure ulcer was actively bleeding. While providing the incontinent care V4 wiped a stool soiled pre-moistened cloth over the pressure ulcer. V4 and V5 both stated that R1 should have on his heel protectors, and they placed them on him. On 2/8/25 at 10:34 AM, V9, Licensed Practical Nurse, LPN entered R1's room to provide R1's right buttock pressure ulcer treatment. V9 cleansed the wound with wound cleaner. The wound bed is red with white edges at the top. V9 measured the wound 3.2 centimeters (cm) long x 1.4 cm wide. V9 applied Hydrogel, Collagen Particles, (Silver Sulfadiazine) SSD cream, calcium alginate and a superabsorbant gauze, and then taped it securely. R1's February 2025 TAR documents, Clean with wound cleanser on right buttock hydrogel, collagen particles, SSD, calcium alginate rope, Cover with super absorbent gauze every day shift for wound care management start date of 1/8/25. This TAR fails to document and order from 2/5/25 of cleanse with wound cleanser, apply collagen particles to base of the wound, secure with bordered gauze. 4. R2's Face Sheet, Print date of 2/10/25, documents R2 was admitted on [DATE] and has diagnoses of Type 1 Diabetes and Paraplegia. R2's MDS, dated [DATE], documents that R2 is cognitively intact, requires partial to moderate assistance for bed mobility, is dependent on staff for transfers, has an indwelling urinary catheter, and an ostomy. R2's Physician Orders, dated 2/7/25, documents, SSD (Silver sulfADIAZINE) External Cream 1 % (Silver Sulfadiazine) Apply to right buttock topically in the morning for wound care management. R2's Physician Orders, dated 2/6/25, documents right buttock clean wound with wound cleanser cover wound with mixture of SSD, collagen filler and hydrogel cover with calcium alginate cover with bordered gauze every day shift for wound care management AND as needed for whenever the wound dressing comes off or dirty. R2's Physician Orders, dated 2/6/25, documents sacrum clean wound with wound cleanser cover with zinc ointment leave open to air every day shift for wound care management AND as needed after bowl movements. On 2/8/25 at 10:52 AM, V8, Registered Nurse, RN entered R2's to provide pressure ulcer treatments. V8 cleansed the sacrum pressure ulcer with wound cleanser, applied a mixture of SSD, hydrogel, collagen particles, calcium alginate, and covered the pressure ulcer with border gauze. The pressure ulcers were 5.5 cm x 4.5 cm. The wound bed was red. The upper left side of the pressure ulcer had scabs. V8 then cleansed the right buttock pressure ulcer with wound cleanser, applied a mixture of hydrogel, collagen particles, calcium alginate, and covered the pressure ulcer with border gauze. The pressure ulcer measured 3 x 1.5. There is a stitch in the middle of the pressure ulcer. The middle is indented, and the wound bed color is dark pink. V8 stated she just may have done the wrong order on the sacrum. V8 did not remove the applied a mixture of SSD, hydrogel, collagen particles, calcium alginate, and covered the pressure ulcer with border gauze. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 2/8/25 at 11:15 AM, R2 stated that she just returned from the hospital because one of the wounds needed to be cauterized because it would not stop bleeding. On 2/8/25 at 2:30 PM, V8 stated she did not use the SSD cream on the right buttock is because R2 was out. On 2/10/25 at 2:30 PM, V2, Director of Nurses, stated that she is unsure why the orders that the Wound Nurse Practitioner are not put in as orders. A pressure ulcer assessment should be done at admission, readmission, or when a pressure ulcer is found. On 2/13/25 at 11:49 AM, V13, LPN/Wound Nurse, stated a skin assessment should be done within the first two hours of admission. If a pressure ulcer is new, it will get a dressing over it, and I notify the Nurse Practitioner or the Doctor to get orders for it. I then put the order in and do the treatment. I do rounds with the Wound Nurse Practitioner. the Nurse Practitioner will go over the pressure ulcer and then what order she wants. If I am not here the floor nurse will go with the Wound Nurse Practitioner. When she changes an order, I put it in right then that way it gets put in the Physician Orders and to the Treatment Administration Record. The Wound Nurse Practitioner will send an email with the wound information and what order she wants. Sometimes it is the same and sometimes it is different. If a dressing is missing it should be replaced as soon as possible. The dressings should be done as they are ordered. On 2/19/25 at 10:48 AM, V14, Wound Nurse Practitioner, stated We are a contracted company, so we are not allowed to put in orders. The nurses here do it. I have 48 hours to turn in my report with the recommendations which are the orders, but they are called recommendations. Once they get that report, the recommendations should be entered as orders and then carried out. If a new pressure ulcer or wound develops the facility should be calling the Medical Doctor for orders. I am only here once a week so when I come next, I will then look at it. The nurses should be putting on the treatments as they are ordered. The policy Skin Management: Pressure Injury Treatment/ General Wound Treatment, dated 4/2024, documents, General Treatment Guidelines; 1. Review the physician order in the EHR (Electronic Health Record) and place all necessary supplies in treatment care. It continues, 6. Perform the treatment as ordered using proper techniques of infection prevention and control. 9. Pressure Injuries will be evaluated, and the following areas documented weekly (minimum every 7 days). Location. Size: Perpendicular measurement of the greatest extent of length and width of the injury using a disposable measuring device. Depth: insert a swab in wound and gloved finer at end, then measure in centimeters. Presence and location (based on the clock) of undermining/ tunneling/ sinus tract. exudate: type, color, odor, and appropriate amount. pain: Nature and frequency. Wound bed: color and type of tissue / character including evidence of healing (granulation tissue) or necrosis. Description of wound edges and surrounding tissue (rolled edges, redness, maceration, etc.) 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. 11. When the Wound Care Team assesses the resident, they will take a picture, measure the wounds, review the orders, and update any notes and care plans as appropriate.