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	05/13/2025

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** 50908 Based on interviews and record reviews the facility failed to follow written orders for wound care treatment for 1 out of 4 residents, (R2); reviewed for quality of care in a sample of 5. This failure resulted in R2 being admitted to the hospital with wounds declining. Findings include: R2's face sheet documented he was admitted to the facility on [DATE] and discharged on [DATE]. R2's face sheet documented his diagnoses were, in part, burn of third degree of right foot, type two diabetes mellitus and encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. R2's Minimum Data Set (MDS) dated [DATE] documented he was cognitively intact. R2's Care Plan dated 4/25/25 documented R2 was at risk for skin complications (entered on 5/4/25) with interventions, in part, to provide treatment as ordered (entered on 5/4/25). R2's discharge summary was faxed from hospital on 4/23/25 to the facility, it included his wound care orders. The discharge summary wound care orders documented the following: Donor site location: left thigh, Xeroform/bacitracin: leave adherent xeroform on donor site. Wash it daily with soap/water to remove any debris/old ointment. Reapply new bacitracin over adherent xeroform then leave it open to air. Trim loose xeroform as it lifts up. Once donor site is heeled (usually 2 weeks after surgery) xeroform should be able to be easily removed to reveal healed pink/dry donor site skin. Graft location: bilateral feet: bacitracin, xeroform and gauze daily to foot burns-separate toes with gauze. f/u (follow up) in 1 week with burn/plastic surgery clinic. R2's hospital discharge paperwork dated 4/23/25 documented to start bacitracin 500 unit/gram ointment on 4/24/25; apply to affected area daily. R2's Progress notes dated 4/28/25 documented V3, Wound Nurse Practitioner, wrote out the same wound care orders as mentioned in the discharge summary. R2's Orders documented on 4/25/2025 at 6:48 AM, are as follow: Left upper leg clean with soap and water cover old xeroform with bacitracin cover with either wrapped gauze or bordered dressing every day shift every Mon, Tue, Wed, Thu, Fri for wound care management. (continued on next page)

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

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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 0684 Level of Harm - Actual harm Residents Affected - Few	R2's Orders documented on 4/25/2025 at 6:00 AM, are as follow: Left upper leg clean with wound cleanser cover wound with xeroform cover with either wrapped gauze or bordered dressing every day shift every Mon, Tue, Wed, Thu, Fri for wound care management. R2's Orders documented on 4/24/2025 at 1:36 PM are as follow: right foot clean with wound with wound cleanser cover with xeroform wrap with gauze every day shift every Mon, Tue, Wed, Thu, Fri for wound care management. R2's Orders documented on 4/24/2025 at 1:33 PM, left foot clean with wound cleanser cover with xeroform cover with wrapped gauze every day shift every Mon, Tue, Wed, Thu, Fri for wound care management. R2's Progress note dated 4/25/2025 at 9:33 AM, documented V4 (Wound Nurse) charted she received a call back from surgeon's nurse and was informed by the nurse that the area where the skin graft was taken from was not to be changed. V4 continued to document We are to wash the area with soap and water and cover the xeroform that is on the area with bacitracin and leave open to air. I explain the clothing sticking to the clothing. Nurse stated that we can wrap it in gauze. I informed the nurse of removing one strip of the xeroform from the area do to what I read from the first set of orders. Nurse question if I covered it back up with xeroform, which I inform her that I did. Nurse stated that it is ok but not to do it again. R2's April Treatment Administration Record documented no wound care was signed off on 4/26/25 or 4/27/25 and there is no PRN (as needed) order for wound care on R2 in the TAR. R2's Progress note dated 4/30/25 at 3:43 PM documented R2 had a temperature of 100.8 degrees but asymptomatic and received new orders for labs. R2's labs collected on 4/25/25 resulted on 4/26/25 with a WBC of 17.10 where the normal range is documented to be between 3.4 - 10.8. On 4/30/25 R2's labs were done again and resulted with a WBC of 15. 25. R2's orders documented Doxycycline Monohydrate Tablet 100 mg (milligram), give 1 tablet by mouth two times a day for infection for 7 Days with a start dated of 4/30/25 at 8:00 PM. Post-op paperwork documented R2 was admitted with diagnosis of wound cellulitis on 5/5/25. R2's Hospitalist Progress note dated 5/6/25 at 2:28 PM, documented under Assessment and Plan: Burn involving 5% of body surface status post grafting 4/16 and full-thickness third degree burns on feet with management per burn primary. Status post-split-thickness skin grafts on 5/5 with bilateral wound VAC (vacuum-assisted closure) in place. Wound cultures from 5/2 positive for Escherichia coli, Enterobacter cloacae, Staphylococcus aureus, Proteus mirabilis and Corynebacterium species. Continue ceftazidime for cellulitis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/12/25 at 9:35 AM, R2 stated his stay at the facility was horrible, the treatment he was supposed to have, he didn't get. R2 stated they rarely changed his wound dressings or washed his feet. R2 stated the day or two right before he was going in for his follow up at the burn clinic, they did the dressing changes completely, out of nowhere. R2 stated he was concerned about getting an infection because it was so dirty at the facility, and they did wound care on the floor of his room not in a cleaned room or on his bed. R2 stated he asked the Director of Nursing (DON) if there was a more sanitary way to clean his feet but was told they'll just do it on his floor. R2 stated when he first arrived, the nurse just started to rip off the dressing from his thigh. R2 stated the nurse came back later and told him she didn't look at the second page of instructions where it said to leave the dressing in place on his thigh. R2 stated one nurse tried giving him wound care and told him she couldn't do it after she completed one of his feet and just left him sitting in his room for an hour with his foot undressed. R2 stated he can only remember the facility changing his wound dressings three times while he was there, his pain increased over time, and the wounds started to smell bad. R2 stated his surgeon asked him what the facility didn't do to his wounds because they shouldn't look the way they did. R2 stated his surgeon told him it pushed his recovery back but hopefully not too far and that his feet aren't as good as they would have hoped. R2 stated because of his stay at the facility he went backwards in recovery from the care they provided and had to undergo another surgery; now he is back in the hospital instead of home. On 5/8/25 at 2:41 PM, V13, R2's daughter in law, stated she arrived on 5/2/25 with R2. V13 stated she handed R2's discharge paperwork to the staff member that helped them get situated and emphasized how important it was because it has everything the facility needs to know on how to take care of R2 including his wound care. V13 stated the next day she went to the facility, and they had no idea what happened to it and said they didn't have any of R2's orders. V13 stated on 4/25/25 she talked to the wound care nurse who was rude to her, she said she had already done R2's wound care but later that day we received a phone call saying she removed R2's thigh dressing that was supposed to stay in place, so she obviously hadn't done his wound care yet or looked at the orders from the surgeon. V13 stated on 4/27/25 the facility was placing R2 on bedrest because when he walks around his bandages get dirty. V13 stated on 5/2/25 she took R2 to his follow up appointment with the surgeon at the burn clinic and he told them he was very sorry, R2's wounds are not supposed to look like this, they have gone backwards from when he was initially admitted with the burns, and he would like to admit R2 right away. V13 stated the surgeon said they could do another skin graft from the other thigh and redo it all. V13 stated on Monday 5/5/25, R2 had both of his feet skin grafted again and they also skin grafted the left thigh donor site from the skin loss that occurred there also. V13 stated all R2's wounds were infected on admission to the hospital. V13 started to cry and stated she thought we were sending R2 somewhere to get taken care of, she just hopes this doesn't happen to anyone else. On 5/8/25 at 10:26 AM, V12, R2's son, stated when R2 first got to the facility he dropped off the discharge paperwork with all the care instructions in it at the nurse's station. V12 stated the wound care nurse must not have looked at the packet because the first day she ripped off a strip of xeroform from R2's donor site that was supposed to stay in place for 2 weeks. V12 stated the facility barely did wound care to R2 and they weren't ambulating him like his surgeon instructed to. V12 stated all the wounds were to be done daily. V12 stated when he took R2 to his follow up appointment with the surgeon, you could smell the infection coming off R2's feet. V12 stated the surgeon said at the follow up all R2's sites failed, and they will probably need to do a skin graft to the donor site, redo his feet and use the other thigh for the skin graft. V12 stated the doctor said all R2's wounds were infected, and he was admitted to the Burn Unit ICU. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/7/25 at 10:30 AM, V4, Wound Care Nurse, stated that R2 came to the facility after burning his feet with tea, he was transferred from the hospital with 5% burns to his body. V4 stated R2's orders initially were to cleanse the sites, apply xeroform and wrap them up. V4 stated when she went to remove the xeroform from R2's thigh, he was in a lot of pain and later found out it was not supposed to be removed. V4 stated because R2 was in so much pain she only removed one strip and stopped. V4 stated she found the wound care orders several hours after she removed the one strip from R2's thigh. V4 stated there was supposed to be bacitracin applied to the thigh, but didn't have that at the facility. V4 stated she notified the surgeon's office and was told to leave the remaining xeroform on and apply more, cover with A&D ointment because the facility did not have bacitracin, and cover the area. V4 stated R2's feet were to be changed daily and PRN (as needed). V4 stated she wasn't concerned about R2's wounds until 2 days prior to him leaving the facility and notified the surgeon and sent pictures. V4 stated she was concerned about R2's wounds the entire time he was at the facility especially because he constantly dropped things on his dressings like urine from his urinal and juice. V4 stated she told the nurses to tell her anytime R2's dressing were wet. V4 stated she wanted to try to keep R2 in bed more to keep his feet safe but was told we couldn't do that. V4 stated two days prior to him leaving, parts were coming off his wound and reported it to the surgeon's nurse. On 5/8/25 at 10:05 AM, V4 stated that V3 (Wound Care NP) told her she could make R2's dressing changes Monday through Friday and PRN (as needed). V4 stated the surgeon's nurse also said R2's dressings could be done as needed. V4 stated she sent a picture of just one of R2's feet when she saw concerns but did not look at the other foot because it had a new dressing on it applied by another nurse. V4 stated the facility did not have bacitracin so she used A&D ointment on the thigh but did not see the discharge orders had instructions to apply bacitracin to the feet also. V4 stated the office only mentioned the xeroform on the phone. V4 stated the PRN wound care orders were not in the TAR, so that is why it does not document R2 had wound care over the weekend, and she had to make Progress notes instead for the treatment administration. V4 stated she had to enter those progress notes late because her computer wasn't working. On 5/7/25 at 2:35 PM, V4 stated wound care is documented as being completed on the treatment administration record (TAR) and should be completed there unless there is a question about the order, then hold doing it until clarifying. V4 stated wounds are supposed to be changed as needed when she is not at the facility by the staff nurses. V4 stated the TAR will show when the last dressing was done. On 5/8/25 at 9:44 AM, V7 Licensed Practical Nurse (LPN) stated when she took care of R2 over the weekend once and she remembered he spilled on his dressing but did not have to change them, she didn't feel comfortable changing his wounds because of how severe they were. On 5/7/25 at 2:56 PM, V11 (LPN) stated wound care is to be done according to the doctor's order. V11 stated she was concerned from the start with R2's wounds because of how severe they were but had never done his wound care. On 5/7/25 at 2:41 PM V9 (LPN) stated the Treatment Administration Record (TAR) will tell you what the wound care orders are, and will follow those when doing dressing changes. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/7/25 at 12:58 PM V3, Wound Nurse Practitioner (NP), stated V4 sent her a picture of R2's wound and it looked like it was failing. V3 stated V4 removed the donor site dressing and told said she didn't see the orders to leave it in place. V3 stated she was not told the facility did not have bacitracin to use on R2. V3 stated she would recommend following orders from the surgeon. On 5/8/25 at 10:52 AM, V3 stated her recommendations were to follow the surgeon's orders on R2 and she did not want to change anything. V3 stated she only put in orders as written by the surgeon. V3 stated she thinks they were supposed to be daily but would have to check the chart to make sure. V3 stated she did not put in for R2's wound care to be done on Monday through Friday and PRN because he was treated by a surgeon and would follow their recommendations. On 5/8/25 at 1:56 PM, V15, Facility's NP, stated she was concerned about infection for R2 after a nurse reported a low-grade fever on Thursday (5/1/25) and thought it could be related to his wounds, so she started him on a broad-spectrum antibiotic. V15 stated not administering the bacitracin ointment as ordered could have contributed to R2's wounds declining, it is an antibiotic ointment. On 5/12/25 at 10:06 AM, V14, Burn Unit Social Worker, stated upon discharge, she notifies the facilities of what patients need for aftercare and they never told her they didn't have bacitracin because if that was the case she would have sent some with R2 before he left. V14 stated the providers did not change any of their discharge orders for R2's wound care after he left and never said to use A & D ointment or to give dressing care Monday through Friday and PRN (as needed). V14 stated the wound care is very particular for burns and skin grafts. On 5/12/25 at 2:25 PM V2 (DON) stated R2 came with a donor site and skin graft wounds. V2 stated she started to have concerns about his wounds when he had an elevated temp and WBC (white blood cell). V2 stated V4 told her she notified the surgeon of this and provided updates on the wounds, but they wanted to hold off on doing anything until they saw him at his follow up appointment which was in the next day or two at that time. V2 stated she expects nurses to follow orders as written from the discharge paperwork and to only put in orders as a provider instructs to do so. V2 stated she was never notified that bacitracin wasn't available, she thought it was being applied to R2 the entire time. V2 stated no one made concerns to her that R2 wasn't getting wound care as ordered. The facility's Treatment/General Wound Treatment Policy dated 4/2024, documented under treatment guidelines to document routine and PRN treatments in the treatment administration record of the EHR (electronic health record) and to document all significant observations in the Nursing Progress Note. The facility's Skin and Wound Management Guidelines revised on 1/3/22 documented on admission or readmission to ensure the treatment order is in place and appropriate. The wound care nurse is to obtain or ensure appropriate treatment order is in place.

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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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews and record reviews the facility failed to follow wound care orders for 1 out of 4 residents, (R2) reviewed for quality of care in a sample of 5. This failure resulted in R2's experiencing severe pain. Findings include: R2's face sheet documented he was admitted to the facility on [DATE] and discharged on [DATE]. R2's face sheet documented his diagnoses were, in part, burn of third degree of right foot, type two diabetes mellitus and encounter for surgical aftercare following surgery on the skin and subcutaneous tissue. R2's Minimum Data Set (MDS) dated [DATE] documented he was cognitively intact. R2's Care Plan dated 4/25/25 documented R2 was at risk for skin complications (entered on 5/4/25) with interventions, in part, to provide treatment as ordered (entered on 5/4/25). R2's orders documented acetaminophen 650 mg (milligram) tablet to be started 4/23/25 as needed for pain/fever/headache and oxycodone 5 mg tablet to be started 4/23/25 as needed for pain. R2's Medication Administration Record documented the first dose of acetaminophen he was given was on 4/24/25 at 8:53 AM and the first dose of oxycodone was administered on 4/24/25 at 11:25 AM. R2's discharge summary was faxed from hospital on 4/23/25 to the facility, it included his wound care orders. The discharge summary wound care orders documented the following: Donor site location: left thigh, Xeroform/bacitracin: leave adherent xeroform on donor site. Wash it daily with soap/water to remove any debris/old ointment. Reapply new bacitracin over adherent xeroform then leave it open to air. Trim loose xeroform as it lifts up. Once donor site is heeled (usually 2 weeks after surgery) xeroform should be able to be easily removed to reveal healed pink/dry donor site skin. Graft location: bilateral feet: bacitracin, xeroform and gauze daily to foot burns-separate toes with gauze. f/u (follow up) in 1 week with burn/plastic surgery clinic. Progress note dated 4/24/25 at 2:38 PM, V4 documented that R2 refused wound care treatment due to pain. After given pain pill and waiting 35 to 40 mins. Went back to resident to try to do wound care. R2 was still in a lot of pain. Resident agreed to let me cover the wound back up. Spoke with facility NP about resident's pain. NP increased frequency of pain medicine given. Called the wound NP and went over different ideas and how to help resident with dressing change and if she wanted to change any of the orders. The only change was to wrap or put a bordered dressing over graft area. Went over plan with R2 about changing dressings tomorrow. R2 did not want dressing change but stated that he will try. R2's son came into voice concerns about treatments. V4 explained R2's pain level and what she discussed with R2. Also went over that surgeon was called and left a voice message to see if anything needs to be changed with wound care due to the pain. R2's son was upset that the wound care was not completed and was worried about R2's mental status. NP called and orders for labs and urine to be collected by tomorrow. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R2's Progress note dated 4/25/2025 at 9:33 AM, documented V4 (Wound Nurse) charted she received a call back from surgeon's nurse and was informed by the nurse that the area where the skin graft was taken from was not to be changed. V4 continued to document We are to wash the area with soap and water and cover the xeroform that is on the area with bacitracin and leave open to air. I explain the clothing sticking to the clothing. Nurse stated that we can wrap it in gauze. I informed the nurse of removing one strip of the xeroform from the area do to what I read from the first set of orders. Nurse question if I covered it back up with xeroform, which I inform her that I did. Nurse stated that it is ok but not to do it again. On 5/12/25 at 9:35 AM, R2 stated his stay at the facility was horrible, the treatment he was supposed to have, he didn't get. R2 stated when he first arrived, the nurse just started to rip off the dressing from his thigh, she didn't try to wet it down or peel it back slowly the way the hospital would do. R2 stated it felt like a strip of skin was ripped off his thigh. R2 stated he was screaming in pain, and they didn't give him medication before doing it; the nurse kept telling him It needed to be done until he finally told her to stop, he couldn't take the pain anymore. R2 stated he looked down at his leg after she ripped of the dressing, and it was bleeding. R2 stated they put in the charts that he refused care and ignored that it was causing him so much pain. R2 stated he's cut off a finger in his past and was treated better for that, they made sure his pain was managed first before providing the wound care but at the facility they didn't do any of that. R2 stated he was in severe pain screaming and she put him through hell. R2 stated the nurse came back later and told him she didn't look at the second page of instructions where it said to leave the dressing in place on his thigh. R2 stated because of his stay at the facility he went backwards in recovery from the care they provided and had to undergo another surgery; now he is back in the hospital instead of home. On 5/7/25 at 10:30 AM, V4, Wound Care Nurse, stated that R2 came to the facility after burning his feet with tea, he was transferred from the hospital with 5% burns to his body. V4 stated when she went to remove the xeroform from R2's thigh, he was in a lot of pain and later found out it was not supposed to be removed. V4 stated because R2 was in so much pain she only removed one strip and stopped. V4 stated she found the wound care orders several hours after she removed the one strip from R2's thigh. On 5/8/25 at 10:05 AM, V4 stated the initial time she took off the dressing from R2's thigh, R2 was in extreme pain. V4 stated we would pre-medicate R2 for wound care after that. On 5/8/25 at 9:44 AM, V7 Licensed Practical Nurse (LPN) stated R2 would complain of his wounds causing him pain. V7 stated the day V4 took the dressing off R2's thigh, he was bleeding, and she had to give him oxycodone after because he was in pain and wouldn't let anyone touch it afterward. On 5/13/25 at 9:53 AM, V16 (LPN) stated she would review orders first and see if there is pain medication to administer to the residents at least 30 minutes prior to providing wound care. V16 stated if the resident was in severe pain, then something is wrong and would stop. V16 stated she would soak the dressing first before removing it if it was dried to the skin. On 5/13/25 at 9:55 AM, V17 registered nurse (RN) stated she would pre-medicate if there were orders to do so prior to wound care. V17 stated she would not continue with wound care if it was causing the resident severe pain especially if it was sensitive. V17 stated she would wet the dressing first if it was dried to the skin before removing only if she had orders to remove it. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/13/25 at 10:56 AM, V2 (DON) stated she would expect the nurses to provide pain management if the resident is having complaints of pain. The facility's Pain Management Policy dated 1/2025 documented it will facilitate and provide guidance on pain observations and management. The policy continues to document the pain management program is based on a facility-wide commitment to resident comfort and pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does. The policy further documented pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals.