STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145656	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Godfrey	1623 29 West Delmar Godfrey, IL 62035

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42636 Based on interview and record review, the facility failed to complete wound treatments as ordered by the physician in 1 of 3 residents (R2) reviewed for pressure ulcers in the sample of 4. Findings Include: R2's Face Sheet, undated, documents R2 has the following diagnoses: Multiple Sclerosis, Local Infection of the Skin and Subcutaneous Tissue, Protein-Calorie Malnutrition, Need for Assistance with Personal Care, Paraplegia, Anemia, Urge Incontinence and Pressure Ulcer of the Left Buttock. R2's MDS (Minimum Data Set), dated 4/24, documents R2 has a BIMS (Brief Interview of Mental Status) score of 12, which indicates R2 has moderate cognitive impairment, and has an unstageable pressure ulcer present upon admission. R2's Care Plan, dated 10/9/23, documents R2 was admitted to the facility with actual skin complications related to pressure injuries of the left buttock, left heel and right heel with an intervention to provide treatment as ordered to the left buttock wound as per POS (Physician Order Sheet) / TAR (Treatment Administration Record) until resolved. R2's Wound Evaluation & Management Summary, dated 4/30/24, documents R2 has a stage 4 pressure ulcer to the left buttock that is greater than 298 days duration. Wound measures 3.2 cm (centimeters) x 5 cm x 0.3 cm. R2's POS, documents an order dated 2/1/24, to cleanse the area to the left buttock with normal saline or wound cleanser. Apply Silvadene, collagen, calcium alginate and cover with a silicone foam bordered gauze every day for wound care. R2's TAR, dated 2/2024, fails to document R2's wound care was completed 4 times. R2's TAR, dated 3/2024, fails to document R2's wound care was completed 17 times. R2's TAR, dated 4/2024, fails to document R2's wound care was completed 5 times. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/24 at 7:50 AM, V2, DON (Director of Nurses) stated R2's pressure ulcer is stable and not getting any worse. V2 stated the nurses document the treatment administration on the TAR. If it is blank for that day, it could be that it wasn't done or they forgot to sign it off. V2 stated this happens mostly with agency staff and when it happens, she tries to contact them to ensure they have completed the treatment as ordered. On 5/7/24 at 1:55 PM, R2 stated she was admitted to the facility with a pressure ulcer on her buttocks. R2 stated the nurses are to change the dressing daily, but she has went up to 3 days before they have changed it. R2 stated the wound isn't worsening, but it's not getting any better. The Skin Management: Pressure Injury Treatment/General Wound Treatment policy, dated 6/2015, documents the following: Document routine and PRN (As Needed) treatments in the treatment administration record of the EHR (Electronic Health Record). Document all significant observations in the Nursing Progress Note.