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	03/04/2025

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on observation, interview, and record review, the facility failed to ensure enteral gastrointestinal feedings and care were provided as ordered for 3 of 3 (R2, R1, R3) residents reviewed for enteral feeding management. This failure resulted in R2 requiring hospitalization for treatment of aspiration pneumonia related to food regurgitation. Findings include: 1. R2 was admitted to the facility on [DATE], with diagnoses of diffuse traumatic brain injury with loss of consciousness, severe protein-calorie malnutrition, dysphagia, and acute respiratory failure. R2's Minimum Data Set (MDS), dated [DATE], documented he is severely cognitively impaired and dependent on staff to assist with all mobility. R2's Care Plan, dated 5/30/24, documented R2 is at risk for complications related to tube feeding with a goal to remain free of aspiration pneumonia throughout next review. Interventions for this care plan are documented to be, in part, administer tube feedings as ordered. R2's Progress notes on 2/20/25 at 7:33 PM documented, (R2) returned from hospital via ambulance with 2 attendants. (R2) is alert per his baseline. G-tube (gastrostomy tube) was replaced, BS (bowel sounds) in all 4 quadrants, abdomen is soft. A surgical incision is present to the midline of the lower abdomen. A drain is present to the left lower quadrant. Urinary catheter is patent. LCTA (lungs clear to auscultation). Edema is noted to the RUE (right upper extremity), including the hand. Some shearing is noted to the buttock. Feedings are 1.5 at 45mL/hr (milliliters per hour) with 120 mL water flushes every 4 hours. R2's hospital discharge orders, dated 2/20/25, documented to start tube feedings at 10mL/hr, advance by 10mL/hr q(every) 6hr to goal of 45mL/hr. An additional hospital discharge order listed included, Scopolamine 1 mg over 3 days patch 3 day place 1 patch on the skin every third day. This is documented as last given on 2/17/25 at 4:01 PM at hospital. R2's facility orders, dated 2/20/25 at 6:30 PM, documented every 24 hours Enteral Feeding Formula 1.5 Rate 45 mL/hr. (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 0693 Level of Harm - Actual harm Residents Affected - Few	R2's Medication Administration Record documented V7 started administration of R2's Enteral Feeding at a rate of 45mL/hr at 9:34 PM. R2's Progress note, dated 2/20/2025 at 9:45 PM, documented, Scopolamine Transdermal Patch 72 Hour Apply 1 mg (milligram) transdermally every 72 hours for nausea unavailable. R2's Progress Note, dated 2/21/25 at 8:30 AM, documented, (R2) has what appears to be tube feeding coming from his trach (tracheostomy) and having large emesis that appears to be tube feeding. (R2) being transferred to the hospital for evaluation. The phone numbers listed for the resident's emergency contact are not in service. The documenter unable to reach POA (Power of Attorney) via telephone to update her on the resident's status. R2's Progress note, dated 2/21/25 at 3:54 PM, documented, This Nurse called local hospital. (R2) is being admitted with aspiration pneumonia r/t (related to) food regurgitation. On 3/4/25 at 11:49 AM, V7, Licensed Practical Nurse (LPN), stated R2 was doing okay when he returned from the hospital on 2/20/25, but she remembers he had swelling to his right arm and hand. V7 stated she put in R2's orders as written in his hospital discharge paperwork. V7 stated she started R2 at 45mL of tube feeding not too long after he returned back from the hospital. V7 stated R2 was also having mucus coming from his tracheostomy that was thick and tan. V7 stated Scopolamine patches were ordered and can help with secretions and with nausea, but it wasn't available. V7 stated she did not call for the doctor for alternative orders. V7 stated R2 was not aspirating while she was at the facility, it happened after she left, and she doesn't know exactly what happened. On 3/4/25 at 9:10 AM, V6, Certified Nursing Assistant (CNA), stated R2 did not verbalize how he was feeling while he was in the facility. V6 stated she was not sure what happened, but he was having trach issues on 2/21/25 before R2 went back to the hospital, although she did not specify what the occurrance was which made her say he was having issues. On 3/4/25 at 11:05 AM, V3, CNA, stated R2 had something coming out of his tracheostomy the morning of 2/21/25 when he was sent back out to the hospital. On 3/4/25 at 12:27 PM, V8, Nurse Practitioner, stated R2 could have had abdominal distention, nausea, and vomiting if his tube feedings were not titrated as recommended. V8 stated starting R2's tube feedings at 45mL/hr could have been too much for him, causing him to aspirate. V8 stated if the Scopolamine patches weren't available, an alternative medication could have been requested to help prevent nausea and vomiting. The patch is also used to help with secretions in patients with tracheostomies. V8 stated she would recommend keeping a resident elevation for at least 30-60 minutes after a tube feeding to prevent aspiration. 2. R1 admitted to the facility on [DATE], with diagnoses of female intestinal-genital tract fistulae, Methicillin resistant staphylococcus aureus infection, and dysphagia. R1's MDS, dated [DATE], documented she is severely cognitively impaired and dependent on assistance with feeding and all mobility tasks. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan, dated 1/15/25, documented R1 is at risk for complications related to presence of a feeding tube. R1 is allowed to have a regular mechanical soft diet and regular liquids for pleasure feedings as ordered; keep HOB (head of bed) raised 30 degrees; elevate the head of the bed 30-45 degrees during feeding, check tube placement by auscultating air injection every shift; check placement of G-tube (gastrointestinal tube) using auscultation before administering food/medications/fluids, check feeding tube residual as ordered; cleanse stoma site daily with soap and water during routine care; may be done by nursing assistant if no open areas; keep HOB raised 30 degrees; and elevate the head of the bed 30-45 degrees during feeding. R1's orders, dated 1/14/25, documented check placement of Gtube using auscultation before administering food/medications/fluids. R1's orders, dated 1/14/25, also documented cleanse stoma site daily with soap and water during routine care; may be done by nursing assistant if no open areas. R1's orders, dated 1/14/25, continued to document monitor enteral tube site for signs and symptoms of infection every shift for skin. On 3/3/25 at 11:03 AM, R1 stated, Sometimes the nurses will give me tube feedings while I'm flat. R1 stated the staff clean her stoma every once in a while. On 3/3/25 at 12:33 PM, V3, CNA, assisted R1 with her fruit cup for lunch. R1 stated she did not like the main dish and would like a substitute, if available. V3 placed an order for grilled cheese as a substitute, mechanically soft. On 3/3/25 at 2:03 PM, R1 stated she would like her tube feeding bolus because she didn't have a large meal. V4, Registered Nurse, provided R1 her tube feeding bolus and water flush, without checking for residual or auscultating to check for placement of the feeding tube. The dressing on R1's G-tube site was dated 2/27/25. R1's G-tube stoma site had tender reddened skin surrounding it. As V4 cleansed R1's G-tube stoma site, R1 stated oww every time it was touched. V4 applied skin prep to the stoma before covering it with split gauze. R1's tube feeding was completed at 2:35 PM. V4 stated she would need to notify the provider to see if they would like to add any new treatment to it. On 3/4/25 at 2:19 PM, R1 was observed as having same dressing from day prior, dated 3/3/25 in place. V9, Licensed Practical Nurse, stated she was not told in report that there were any concerns seen yesterday for R1's stoma site, and did not look at it today since R1 did not require a bolus feeding. V9 left the soiled dressing in place and did not remove it to assess the skin, despite R1 reported it being tender. 3. R3 was admitted to the facility on [DATE], with diagnoses of spastic quadriplegic cerebral palsy, unspecified severe protein-calorie malnutrition, and chronic hepatic failure. R3's MDS, dated [DATE], documented she is rarely/never understood, is dependent on assistance with eating and requires substantial/maximal assistance with rolling left and right on the bed, sitting to lying on the bed and lying to sitting on the bed. R3's Care Plan, dated 1/24/25, documented tube feeding: R3 is at risk for complications related to gastrostomy tube placement due to history of BMI (body mass index) of 9.0, recent weight loss and diagnosis of severe malnutrition; check feeding tube residual as ordered; check tube placement by auscultating air injection every shift; keep HOB (Head of Bed) raised 30 degrees. (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	R3's active orders, dated 10/23/2024 at 10:00 PM, documented, Cleanse stoma site daily with soap and water during routine care. May be done by nursing assistant if no open areas. Apply antibacterial cleanser to a 2x2 drain sponge. Allow to set for 10 minutes or longer. Using a cotton tip applicator, apply cream twice daily and PRN (as needed). R3's active orders, dated 10/23/24 at 8:58 PM, documented: check placement of G-tube using auscultation before administering food/medication/fluids. On 3/3/25 at 3:31 PM, V5, LPN, went to R3's room to administer her enteral tube feeding that was due at 2:00 PM. V2, Director of Nursing (DON) was present during the treatment. V5 did not gown up while administering R3's tube feeding. V5 did not auscultate to check for placement of R3's Gtube prior to administering her bolus. V2 stated R3 is on Enhanced Barrier Precautions (EBP) for having a G-tube. R3 did not have a dressing on her G-tube stoma site. At 3:40 PM, V2 stated the day shift nurse didn't have time to apply another dressing to R3's site while they were here. V5 is supposed to do that during her shift, at some point. V2 stated she expects a dressing to be in place on R3's stoma site. V2 stated she expects any staff with direct contact to a resident on EBP to be gowned and gloved up while providing care. On 3/4/25 at 2:05 PM, V9, LPN, administered a bolus of tube feeding to R3 without auscultating to check for placement. On 3/4/25 at 2:30 PM, V1, Administrator, stated, (R2) was admitted to the hospital with pneumonia, and he will not be returning to the facility. I saw firsthand, (R2) had tube feeding coming out of his trach (tracheostomy) and mouth the morning of 2/21/25. I expect the nurses to follow discharge orders as recommended, and absolutely notify a provider if a prescription isn't available to see if an alternative medication can be given. V1 stated she expects her nurses to check for placement of G-tubes prior to administering anything, either by auscultation or checking for residual, but always to find a way. V1 stated she expects staff to be following EBP while providing tube feeding care and to be providing care as ordered/written in their charts and per facility policy. The facility's Tube Feeding Policy, dated 9/2024, documented the following guidelines: check tube placement by aspiration or air insertion, head of the bed should be elevated 30-45 degrees unless ordered differently, check for placement using auscultation prior to flushing, the site is cleansed with soap and water during daily care, turn on pump, set prescribed rate and start feeding, and the CNA will clean the tube site during routine care; should there be any issues with the site, the CNA will notify the nurse who will communicate with the health care provider. The facility's Enhanced Barrier Precautions Policy dated 10/16/23, documented, Our facility employs the use of Enhanced Barrier Precautions (EBP) to reduce transmission of MDROs (multi-drug resistant organisms) to staff hands and clothing that employs targeted gown and glove use during high-contact resident care activities. Staff utilize gown and gloves for high-contact resident care activities when residents require EBP; high contact activities may include Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.