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	03/31/2025

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to ensure a resident's discharge was complete, including housing, Durable Medical Equipment (DME), and medications needed prior to discharging the resident to the hospital, and then failing to accept the resident back to the facility upon hospital discharge for 1 of 4 residents (R2) reviewed for transfer and discharge requirements. This failure resulted in R2 having to find a place to live, not having appropriate DME, and not having medications available as needed. The findings include: R2's Admission Record, dated 3/26/25, documents R2 was admitted to the facility on [DATE], and was discharged to the hospital on 3/5/25. R2's diagnosis include: Spinal stenosis cervicothoracic region, Type 2 Diabetes Mellitus (DM), nicotine dependence, rhabdomyolysis, suicidal behavior, major depressive disorder, alcohol use, hypothyroidism, hypertension (HTN), bipolar disorder, mood affective disorder, encephalopathy, spondylosis with myelopathy, and osteoarthritis. R2's Care Plan, dated 12/27/24, documents R2 requires assist with daily care needs, R2 has alteration in comfort, R2 requires the use of Psychotropic medication to assist with managing mood and behavior, R2 has a self-care deficit in dressing and grooming, R2 is a high risk for falls, R2 is a high risk for skin complications related to dependence on staff for toileting, transfers, and repositioning activities of daily living (ADL). R2's Minimum Data Set (MDS), dated [DATE], documents R2 was cognitively intact, and was dependent on staff for transfers and toileting. R2 required substantial/maximal assistance for bathing. On 3/24/25 at 2:38 PM, V12, Registered Nurse (RN), stated I am an emergency room (ER) nurse at the (local hospital) and was working when (R2) came to our ER from the facility due to behaviors. The facility assumed that (R2) was going to be admitted , but once he was evaluated by the physician, (R2) did not meet criteria for admission, and when we tried sending (R2) back to the facility, the facility refused, and stated that (R2) was discharged and not allowed to return. I know that (R2) was a difficulty patient and I was told that (R2) was to be discharged to an apartment, but that apartment was not ready, and we needed to send (R2) back to the facility because he had no place to go. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 3:55 PM, R2's Community Social Worker, stated, I worked with (R2) in getting senior housing, or an apartment. (R2's) apartment lease was signed, and it was ready on 2/28/25 for him, however, his daughter was supposed to coordinate with a moving crew to get all his belongings from his original home to his apartment, and she did not do that. (R2) did not have any furniture or belongings in his apartment when the facility discharged him. Also, the facility sent the DME request to a medical supply store, and did not do it correctly, and (R2) did not have any DME set up at his apartment. I called the store, and they said it was an incomplete referral form that they could not approve or fill. I was contacted by the Social Worker from the hospital (R2) was in because (R2) was supposed to be discharged , but did not have any place to go, because the facility refused to take him back. It just so happened that I am neighbors with (R2's) daughter and friends of his family, and I have a B&B (Bed and Breakfast) that was open for the weekend, so I let (R2) stay there until Monday (3/10/25). (R2's) daughter had everything ready for him on that Monday, so he moved into his apartment that day. (R2) didn't even have any of his medications from the facility, so he is working with his physician to get his medications. On 3/25/25 at 12:45 PM, V1, Administrator, stated, I was called on 3/5/25 for (R2) being loud, throwing things, screaming, pinning staff against wall, and threatening suicide-- at times indicating he was going to hurt himself. (R2) was putting all the staff and other residents at risk for harm because he was going everywhere in the facility doing these things. (R2) had other residents scared. We contacted the Psych Nurse Practitioner (NP) who gave the order to put in an Involuntary Admission to (local regional hospital). The staff had the Police and Emergency Medical Service (EMS) trying to help them. (R2) had a discharge order, dated 2/27/25, to discharge home. On 3/25/25 at 12:50 PM, V3, Social Service Director, stated, (R2) was scheduled to be discharged from the facility to his home the next day. I worked almost daily with (V7, R3's community Social Worker) about (R2's) discharge and plans. I had follow-up appointments, DME, and Home Health set up for (R2) and he was to go to his physician appointments where (local home health) would get their orders. I thought (R2) had an apartment ready to go once he was discharged from the facility, but when he had his episode, (R2) was sent to the hospital and should have been discharged to his home from there. I was not aware of (R2's) apartment was not ready for him. I have many emails regarding (R2's) DME, and I was never told that it was not filled or that it was declined. An email from V7 to V3, dated 3/5/25 at 9:10 AM, documents some confusion as to if the DME has been ordered or approved. R2's Social Service Note, dated 3/7/25 at 2:12 PM, documents, Writer sent DME signed notes from nurse prac (Nurse Practitioner) and patient, to continue with getting (R2) the equipment he needs for home. This was two days after R2 was discharged . On 3/25/25 at 2:50 PM, V3 stated, I spoke with (V7) who helped (R2) get his apartment set up, and according to (V7), (R2's) apartment move-in date was on 2/28/25. I was sent (R2's) apartment lease indicating his apartment move-in date was 2/28/25. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 3:25 PM, V1, Administrator, stated, (R2) was supposed to be discharged on [DATE], and when that date came, (R2) decided he didn't want to go and wanted to stay for more therapy. Then when therapy tried to work with him, he declined, and refused to work with them. Each time he was scheduled to leave, he changed his mind. When he had the incident, we had to do the involuntary psych admit/eval and we all thought, and I was even told, that the hospital would admit (R2) and then get treated and be discharged home from there. I assumed that (R2) would be admitted , and did not even think he would be discharged that same day. I called my boss and was told to go ahead and discharge him from the facility, and let the hospital discharge him to his home. Everyone from the EMS guys to my boss told me that (R2) would be admitted for a psych eval due to the involuntary form that we filled out. I was not aware until now that (R2) was not admitted , and I assumed that he was discharged to his apartment from the hospital after his stay. I would never put anyone out on the streets with nowhere to live, and would have absolutely let (R2) come back to the facility if I would have known that. I did not even think of (R2's) psychiatric status that day and his ability to go home by himself, because I assumed he was going to be admitted , and the hospital would treat him and help him with his discharge home. Normally on a Resident Initiated Discharge, the resident signs a discharge packet and the nurse will go over all their medications with them and they sign it off together. Then each interdisciplinary department signs off on what is recommended for that resident. Since (R2) was discharged to the hospital and not home, the nurse did not go over his medications with (R2) because they thought the hospital would do that. (R2) has hard scripts for his medications that were sent with his paperwork. I guess I learned something today, that an involuntary psych eval does not necessarily mean that person would be admitted . We probably should have waited until we found out his status, and then discharged him. R2's NP Psych Note, dated 2/28/25, documents, Findings in Patient ' s Room: Upon entry, it was discovered that the patient was in possession of a vape containing THC (tetrahydrocannabinol). The administrator addressed this issue with the patient, explaining that this is a violation of facility regulations. The patient became rude and demanding, insisting that he needed a day pass. Discussion and Facility Policy Violation: The patient was informed that his actions violated facility policies, potentially endangering both himself and other residents. Despite this, he continued to debate the issue and demonstrated a lack of insight into the consequences of his actions. I explained to him that a day pass is not an urgent or emergency matter and that further evaluation of his safety and the well-being of other residents is necessary. Discharge Planning and Additional Concerns: Discussed discharge planning with the patient, but he does not appear to have a clear or definitive plan for placement at this time. Given the situation, I am ordering a urine drug screen (UDS) to further assess for substance use. If the patient experiences a significant change in condition that poses a risk to himself or others, I recommend sending him to the ER for further evaluation. R2's Social Service Note, dated 2/27/25 at 12:30 PM, documents, (3/5/25) Late Entry: Note Text: Discharge Plan: Resident signed lease for d/c (discharge) with daughter/his own social services (V7). Resident plans to leave facility Tuesday 3/4/25 to discharge home. R2's Nurses Note, dated 3/3/25 at 1:52 PM, documents This nurse presented (R2) with a NOMNC (Notice of Medicare Non-Coverage) for last covered Medicare-A day as of 3/5/25. He doesn't wish to appeal at this time, and still plans on returning home with community care giver assistance. He is aware he is able to appeal the decision and has to do so before noon on 3/4/25. He did sign the NOMNC at this time. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's NOMNC, dated 3/3/25, documents R2's last day covered was 3/5/25. R3 signed this document on 3/3/25. R2's Nurses Note, dated 3/5/25 at 12:10 PM, documents, Note Text: at 1130 (11:30 AM) resident came out of room being aggressive combative and screaming threats to staff demanding meds. He has already been informed by the night nurse and me that the Oxy (Oxycodone) he is requesting is on order with pharmacy and that they will deliver tonight or tomorrow morning. he was given his last dose of Oxy last night at 2100 (9:00 PM) and educated by night nurse that was his last dose until the other is delivered via pharmacy. All morning meds were given to resident this morning except for the Oxy which was explained to him numerous times as to why it wasn't given to him. 911 called. When the police arrived resident yelled at them also stating that is the only way to get things done around here. He also stated he didn't care if he was getting sent out for a psych eval regarding his actions. Police and EMS are currently with resident while he is talking to his daughter on the phone. Resident's daughter is currently his POA (power of attorney). EMS refused to take resident stating it is non-medical. Resident is currently in room screaming in an uproar. This nurse has spoken with resident's daughter regarding situation and has referred her to speak to management r/t (related to) her having multiple questions for management. This nurse has relayed message to contact her regarding her concerns. R2's Nurses Note, dated 3/5/25 at 1:08 PM, documents, At this time I received an order as follows due to resident spitting on others, stating he wanted to harm himself, assaulting staff members and refusing to go to the hospital for evaluation. Send resident as an Involuntary Admission to (Local Regional Hospital) via Psychiatric Nurse Practitioner, related to diagnoses of personal history of suicidal behavior, bipolar disorder and major depressive disorder for a psychiatric evaluation. Order noted. R2's Nurses Note, dated 3/5/25 at 2:37 PM, documents, After sheriff and EMS left they were called back to facility for resident r/t him becoming suicidal. He threw glass across room causing it to break. Resident taken to (local regional hospital) at 1345 (1:45 PM). NP called for involuntary discharge to be initiated per Admin. Resident is not to be accepted back to facility per Admin. POA has been made aware regarding situation. R2's Nurses Note, dated 3/5/25 at 6:28 PM, documents, (V12), RN from (local regional hospital) was asking why we won't take resident back, This Nurse gave (V12), RN, (V1, Administrator's) phone number. Explained to not yell at this writer and to get a hold of the Administrator regarding this issue. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Administrator's Note, dated 3/5/25 at 6:31 PM, documents, Writer was called around 12:30 (12:30 PM) by the Social Services Director (SSD) to inform me that this resident came out of his room being combative, yelling, threatening staff, spitting on staff, throwing glass and breaking it in his room, going to the dining room where other residents were just to yell and curse which made many residents uncomfortable. (R2) also cornered a staff member on the hall causing her not to be able to get around him. I was told this resident stated he was suicidal but when asked if he was suicidal or if he had a plan he would laugh at the police and EMT and say he was just playing. Because of this, I asked that (R2) be added to 1:1 to ensure the safety of him and other residents. Resident continued to yell and show aggressive behavior so I then called (local hospital) EMT (Emergency Medical Technician) department to ask why they would not transport this resident out. I made the EMT manager at (local hospital) aware of all that was going on and he asked to call me back. When he did, he stated that we needed to have an involuntary admission form filled out. I then called psych NP for guidance and approval to have this form filled out and signed. She agreed. I was informed that any RN could sign this form since she was not in the facility. I then called the Social Services Director and the Nurse Manager to assist them in filling this form out. While speaking to them the EMT Manager had come to the facility to see exactly what was going on. He again stated that they needed the involuntary admission form because he was witnessing how this resident was acting but because this resident was A&OX4 (alert and oriented to person, place, time, and event) and refusing to go and had not broken the law his team could not take him without the form. I told him they were in the process of filling it out. To my knowledge this form was given to (EMS manager) along with (R2's) discharge order and documents. Shortly after this resident was taken by EMT. I called his POA and daughter to update her on everything and that her father had been sent out to (local regional hospital) in (area town) with an involuntary admission form and his discharge order. This resident planned to be discharged from this facility on 3/4 or 3/5 of this week to his home. It was discussed that (R2) was discharged from our facility and would return home after his hospital stay at (local regional hospital). POA was at work and not happy that her father was unhappy and having these behaviors. She wasn't happy that she was being called numerous times concerning this. She stated that nobody ever called her before this to update her on her father's care. I reminded her that she requested a care plan meeting, and a date and time were set and agreed to, and she never showed up or called us. I also told her our SSD had tried to reach her but (R2) had given the wrong number for his daughter and then asked that she not be called by anyone other than him. R2's Administrator Note, dated 3/5/25 at 7:17 PM, documents, Writer was called by the facility nurse to update me that she had spoken with (local regional hospital) Nurse and was told they were sending this resident back to (this facility). I informed this nurse that we were not to readmit this resident because he was discharged to the hospital, and after he is discharged from the hospital, he will then go to his home. She asked if she could have this nurse call me and I agreed. Shortly after I spoke with the (local regional hospital) nurse she stated that (R2) did not have an IVD (involuntary discharge) form. I told her he did not need one. He was to be admitted to them with the involuntary admission form and he has discharge orders. That after his visit with them, he will return to him home. His Social Worker who he has had out in the community is aware of this discharge to his home as they have been working on this for weeks. This community social worker has also updated his daughter on his plan to be discharged . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Social Service Note, dated 3/5/25 at 12:30 PM, documents, (R2) was in the hall 300 today being disruptive screaming very loudly and being aggressive, in staffs face spitting on staff while yelling, saying verbal threats along with calling staff disrespectful names. (R2) was asked to quiet down he was informed that he was being disruptive towards other residents living in the facility and staff working. (R2) responded screaming back towards staff saying F**k you B**ch, I'm going to cause hell today. Resident was asked to not use profanity multiple times. Staff began to redirect (R2) multiple times back to his room to talk quietly, he then began cornering a staff member up against the wall grabbing onto the hall rail blocking her against the wall screaming in her face. Nurse called police. (R2) was then asked to calm down and was informed that police have been called he then started to scream at the residents in the dining room very loudly saying Hey everybody, this is a F**king sh*t hole, hey everybody I'm going to scream all day if I have to. Police then arrived to facility, writer walked them down to his hall (R2) was sitting in the hall with staff still screaming when police arrived, he was then asked by police to calm down he refused he then stated that if police took him he would love to see it because he will kick, push, and throw his hands and put up a fight. Police then got him to his room EMT arrived they placed him in his bed they began asking him what his concerns and issues was he screamed This is a sh*t hole. EMT then mentioned resident made a suicidal remark but quickly laughed about it and said he was joking he knows the game and he will play it EMT mentioned to writer if it is not medical emergency they cannot take him. EMT left the facility stating that police deal with the situation since it is not medical. Police told writer resident is A&Ox4 and they cannot take him if he is not willing to consent to go to hospital for a psych eval, stated he was refusing to go. I then began to call POA of Healthcare for (local) County police there was no answer, voicemail was full. At this time Police did take resident out of facility, police sat outside of facility before they could leave, they were aware of a 911 call from (R2) calling inside the facility off his own personal cell phone. (local) County Police stated they were going to let residents know that if he calls 911 giving false accusations over 4 times he will then be charged with a felony. While resident was speaking with police and under 1:1 observation by CNA, supervisor writer then was told to assist in completing an Involuntary Admissions Form to (local regional) Hospital for a psych eval by the administrator per her conversation with NP. This form was giving to the Manager of (local) Hospital EMT along with d/c orders and proper documentation. R2's Physician Order, dated 2/27/25, documents May discharge patient to Home. R2's Physician Order, dated 2/28/25, documents May discharge home with all medications and continue as ordered, standard measure wheelchair of 18x16 with swing away footrest and swing back arm rests, PT (physical therapy)/OT (occupational therapy) and home health nursing services. R2's Physician Order, dated 3/5/25, documents Send resident as an Involuntary Admission to (Local Regional Hospital) via Psychiatric Nurse practitioner related to diagnoses of personal history of suicidal behavior, bipolar disorder and major depressive disorder for a psychiatric evaluation. R2's Discharge Plan Assessment located in Forms in his Electronic Medical Record (EMR), dated 2/27/25, is blank and has not been completed. R2's Discharge Instructions located in Forms in his EMR, dated 2/27/25, is blank and has not been completed. There was no Bed Hold located for R2's discharge to the hospital on 3/5/25. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/25 at 1:25 PM, V1 stated, I will be going over the discharge policy with those people and departments involved to reeducate them on their part of the discharge process. The policy clearly states what should be done and to follow-up to make sure things have been done. I'm using this as a learning process for all of us and going forward, I will expect the staff involved to ensure things have been set up prior to a resident's discharge. The Facility's Discharges Policy, dated 9/2017, documents, Guideline: Discharge to Home: 1. Discharge potential is assessed by Social Service on admission. 2. When the IDT, in conjunction with the resident/patient and family determine that a resident/patient is ready to be discharged , the physician is contacted for an order. 3. Social Services will meet with the resident/patient and/or family to set up outside services and equipment. 4. A Discharge Instruction Form is initiated by Social Services or Discharge Planner and finished by the IDT. 5. If medication is to be sent with the resident, a physician order is necessary. 6. Teaching will be done with the resident/patient/family on any dressings or special tasks. This will be documented in the medical record. 7. If necessary, dietary will provide any special diet instructions. 8. If necessary, Therapy will provide any necessary instructions. 9. On the day of discharge, the nurse will review the discharge instruction form, as well as the medications with the resident/patient and/or representative. 10. The patient/resident and/or representative must sign the Discharge Instruction form. A copy of the signed form is given to the family and a copy of the signature sheet is scanned into the EMR. 11. The nurse will have the patient/resident or responsible party sign the current Medication Summary Sheet/Discharge Medication form or the designated pharmacy form for the facility. A Signed copy will be given to the patient/resident or representative. A Signed copy will be scanned into the patient's EMR. 15. The Social Service Department will enter a Discharge Summary Progress Note into the patient's EMR upon planned discharge from the facility. 16. The Discharge Summary Progress Note is to include a summary of the patient/resident stay while in the facility. The Discharge Summary Progress Note should include where the patient/resident was admitted from, reason patient/resident was admitted , services received during patient's/resident's stay, patient's/resident's goals during facility stay, whether the goals were met during the facility stay, and discharge disposition. Hospital Transfer: 1. Notify the physician regarding a change in resident/patient status and obtain an order for transfer to the hospital. This may be a direct admit or an emergency room admission. 2. If attending physician is not available, contact the medical director. 3. Arrange transportation, either paramedics or ambulance depending on the status of the resident/patient. 4. Inform the resident/patient and the resident's/patient's responsible party of the transfer. 5. Prepare an eINTERACT transfer form. 6. Document in the progress notes the condition of the resident/patient, who was notified of the transfer, where the resident/patient is going, mode of transportation, disposition of resident/patient belongings and medications, notification to all parties of the discharge.