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	08/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision and interventions to prevent falls for 1 of 3 residents (R2) reviewed for falls. Findings include:R2's undated face sheet documented she was admitted to the facility on [DATE], with diagnoses including anxiety, hyperlipidemia, hypertension, altered mental status, and dementia.R2's Minimum Data Set (MDS), dated [DATE], documented she has memory problems and is moderately cognitively impaired. The MDS documented R2 requires set-up assistance for eating and requires staff supervision for all other activities of daily living (ADL's). R2's care plan, dated 7/15/25, documented R2 is a currently at a high risk for falls with a goal that she will remain free of falls. Her interventions for this care plan include: encourage appropriate use of wheelchair, evaluate multiple falls to determine any patter, fall risk assessment quarterly and as needed, keep bed in lowest position, keep frequently used items within reach, monitor for changes in gait or ability to ambulate, move resident to room with optimal visual access from nurses station, notify medical doctor (MD) and family of any new fall, promote placement of call light within reach, provide proper, well maintained footwear, provide resident with night light, restorative care as appropriate, rounding at a minimum of every two hours, staff to assist as needed and therapy to evaluate and treat as indicated.R2's care plan, updated on 7/31/25, documented bed to be placed in lowest position when in bed. R2's care plan was updated 8/4/25 after a fall with the interventions including therapy to screen for strengthening and position and send to local hospital emergency room (ER) for evaluation. On 8/5/25 at 1:48 am, after another fall, the only intervention added to the care plan was to send to local hospital ER. There was no other intervention added for this fall. On 8/5/25 at 9:47 pm, R2 had a third fall with the intervention added to send to local hospital ER for evaluation and floor mat to open side of the bed. On 8/2/25 at 9:45 am, V1 (administrator) and V13 (MDS director) stated R2's only intervention for her second fall on 8/5/25 at 1:48 am was to send R2 to hospital ER. There was not an intervention added that would keep her safe from falling again. On 8/4/25 at 8:19 pm, R2's progress note documented R2 was observed lying supine on floor in front of the nurse's station. A small skin tear to the outer right elbow is noted, no other visible injuries. R2 was transported to local hospital via emergency medical services (EMS).On 8/18/25 at 3:55 pm, V8, Licensed Practical Nurse (LPN), stated on 8/4/25 in the evening, R2 had been sitting in front of the nurse's desk in her wheelchair for close observation, when V8 went to assist another resident urgently. When V8 came back up to the nurse's station, R2 was lying on the floor. V8 stated that the cameras were reviewed and looked like she had slid out of the wheelchair on her buttocks. V8 saw no injuries, but due to her receiving blood thinners, R2 was sent out to the hospital. V8 stated prior to R2 falling, she was on fall precautions and staff were checking on her frequently. On 8/20/25 at 9:10 am, V1 stated the timing of frequent monitoring varies depends on each situation and could be every 15 minutes, every hour, or every two hours.R2's fall investigation, undated, or the fall on 8/4/24 at 8:09 pm, documented interdisciplinary team (IDT) met and documented upon investigation, it was found the fall is the result of R2 attempting to get up from the wheelchair without help. The interventions include sending R2 to evaluation and treatment. Upon return physical therapy is to screen for strengthening and positioning. On 8/18/25 at 11:15 am, V3, Registered Nurse, (RN) stated R2 returned to the facility on 8/5/35 at 12:49 am, and the EMS attendant placed R2 in bed. V3 stated she was at the facility about an hour and fell out of bed again. V3 stated V4, Certified Nursing Assistant (CNA) was the CNA working that night and was sitting in the hallway across from R2's room to keep a close eye on her. When V4 went into her room, R2 was lying on the floor. V3 stated she assessed R2 had a laceration in the back of her head, and due to R2 receiving blood thinners, V3 sent R2 out to the hospital again. V3 stated R2 was alert to self and described her as impulsive.On 8/5/25 at 12:49 am, R2's progress notes by V3 documented R2 returned to the facility per EMS, who assisted R2 in bed and call light placed in reach. No new orders received from local ER at time of return to the facility. V3 documented range of motion (ROM) and Neuro checks within normal limits (WNL) for R2. CNA staff aware of the need to frequently to monitor resident post-fall. On 8/20/25 at 9:21 am, V4 stated on 8/5/25 during her night shift, she was sitting in the hallway outside of R2's room, a little to the right of the doorway across the hall. She stated from that vantage point she could not directly visualize R2, but was able to get up often and check on R2, along with all of her other residents on the hallway. V4 stated she kept going back and forth checking on R2 frequently. V4 stated she didn't think about sitting at her doorway because she was also thinking of being available for all her other