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	12/19/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure the alleged perpetrator of an abuse allegation did not have access to residents when an allegation of abuse occurred, and failed to ensure all abuse allegations were investigated. This has the potential to affect all 50 residents living in the facility. Findings include:R10'S Physician Order Sheet (POS) for December 2025 documents a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Type 2 diabetes mellites with other specified complications, muscle weakness, acquired absence of left leg below knee, major depression disorder, single episode, several without psychotic features, and dependence on wheelchair. R10's Minimum Data Set, dated [DATE], document R10 has an impairment on both his upper and lower extremity on one side. R10 was cognitively intact for decision making of activities of daily living, uses a wheelchair and needs substantial assistance for most ADL's (activities of daily living). R10's Care Plan includes: ADL (Activities of daily living): (R10) requires assist with daily care needs r/t (related to) left sided weakness from a CVA. He has a BKA (below knee amputation) of the left leg and requires assistance with transfers. He prefers to have the open side of the bed to the right side to help facilitate bed mobility as that is his strong side. He was placed on restorative dressing/grooming and Transfer programs. R10's Care Plan does not address abuse or document R10 has a history of cussing out staff.R10's Initial Report, dated 11/27/2025, documents, It was reported on 11/26/2026 there was an alleged verbal abuse altercation between (R10) and (V13). Investigation initiated. Final to follow. R10's Final Report date of incident 11/27/2025, documents, (R10) is a [AGE] year-old male. An alleged verbal altercation was reported to have taken place between (R10) and (V13) on 11/26/2026 at approximately 7:55 PM. This was an unwitnessed conversation. Due to the lack of supporting documentation and statements the alleged altercation cannot be substantiated. Staff were in-serviced on customer service and one on one support was provided to the resident. R10's Progress notes, dated 12/2/2025 at 10:52 AM, documents, Late Entry: Note Text: Writer spoke with residents about the abuse allegation he reported. Resident stated he had no further issues and was happy with the follow-through from staff investigating the situation. I asked the resident if he felt safe and comfortable here at the facility, and he stated that he did. Resident was in good spirits. R10's Progress Notes do not document anything related to the allegation of abuse on 11/27/2025. Statement from V14, Licensed Practical Nurse (LPN), documented (V13) came up to the desk and kept talking and yelling about how (R10) had apparently called her out of her name (sic). She was going on about how she wasn't in the resident room and that another CNA (certified nursing assistant) was told she needed less hours. Upon speaking with resident, he stated he said bc (because) this CNA weeks ago, asked or told him why he can't use the bathroom. Resident stated CNA came into his room and yelled at him asking why he cusses at her. This nurse along with agency nurse told CNA to clock out and go home. CNA went to sit in a coworker's car, after she proceeded to stated it was cold outside and wasn't leaving bc (because) she had a ride. She proceeded to sit at the desk, calling myself and the other nurse fake. The level of disrespect from CNA is crazy, I've dealt with from a few that still work there. I should have sent her home earlier, but I was busy on my hall on top of dealing with that. Statement from V13, CNA documents, I was told by another coworker that (R10) called me out my name (sic) and was saying mean stuff about me while she was changing him. All I wanted to know was what was wrong. I have not had him in a while. Went down to his room to ask him was everything okay. Did I do something to make him mad? He started cussing me out. Tell me to get the fuc* out of his room and that I don't need to work here. I'm not shi* and stuff like that. I never cursed at him. I just asked him what was wrong. That's the only thing I asked him. He tried to record me and everything and not once did I cuss at him I though he hadn't said nothing to me all day yesterday 11/26 I work 16 hours do not even have the set he was on so I was just trying to figure out what was the problem. Had a situation about a month ago and it got handled but why are you bringing up a situation that already got handled by the administration? Telling the aide anything about me? And for him just trying to figure out what was the problem. Had a situation about a month ago and it got handled but why are you talking about me to somebody and why are you bringing up a situation that already got handled by the administration. Telling the aide anything about me. And for him to call me out my name and talk to me that way he did was not right, there needs to be a level of respect when it comes too these residents just like we have to respect them as well. This is not the first time he cussed me out or other staff out. The nurses that were on shift treated me as if I did something wrong and I did nothing

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to ensure a resident with history of falls was assessed appropriately by nursing staff after a fall. This failure would have resulted in a reasonable person enduring pain for over a day due to a rib and clavicle fracture until nursing staff was notified completed an assessment. Findings include:R2's December 2025 Physician Order Sheet (POS) documents a diagnosis of Parkinson's disease with dyskinesia, with fluctuations, chronic respiratory failure, severe protein calorie malnutrition, traumatic subarachnoid hemorrhage without loss of consciousness, abnormal weight loss, delirium due to physiological condition, and anxiety disorder. R2's Minimum Data Set (MDS), dated [DATE], document R2 was severely impaired for cognition for activities of daily living. R2 uses a wheelchair and requires substantial/maximal assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. R2's Care Plan: Falls documents, (R2) is at risk for falls. Cognitive deficits, Functional Deficits, Poor Balance, Use of Psychotropic Medication. Date Initiated: 11/27/2023. R2's Progress Notes, dated 11/25/2029 at 1:29 PM, Note Text: CNA'S reported to nurse that resident had a fall yesterday evening 11/24/25, around dinner time, CNA's got resident up without nurses knowledge, ROM (range of motion) and skin assessment provided this shift, resd (resident) does not want staff to touch her arm, Hospice assessed resident with orders to send to ER (emergency room) for eval (evaluation) and tx (treatment). R2's Progress Notes, dated 11/26/2025 at 2:10PM, Note Text: Call received from (Hospice Nurse from Hospital) DX (diagnosis of UTI (urinary tract infection) with new ABT (antibiotic orders), Multiple rib fractures and Fractured clavicle. On call Nurse to have PRN (as needed) Morphine for pain control delivery of pain medication to the facility for resident's comfort and pain control. R2's Hospital Report, with an encounter date of 11/25/2205 at 2:39 PM, documents, I called (Facility) and spoke with nurse. She reported that the patient was found on the floor yesterday around dinner time. She states that somehow, she must have fallen out of her wheelchair. Stated that the medical assistant found her and did not report it to any nursing staff. Nursing staff found out this morning that the patient fell yesterday evening. Nurse stated that the patient had pain to her left shoulder when examined. The patient is nonverbal, bed bound unless in a wheelchair up for food and does not feed herself. Elderly, frail patient observed bed bound in chronic flex/fetal posture, consistent with contractures, Requires full assistance with positioning. The CT scan final results dated 11/25/2025 document, 'the medical portion, right clavicle, the anterior aspect right first, and second ribs are angulated with cortical irregularity could indicate subtle acute fractures. Closed fracture of multiple ribs of right side, initial encounter, closed, nondisplaced fracture of shaft of right clavicle, initial encounter.R2's Initial Report, dated 11/24/2025, documents, Resident had fall with injury. Investigation initiated DON (Director of Nursing), POA (Power of Attorney), MD (Medical Doctor) notified. This is our initial report 5 day to follow. R2's Final Report incident date of 11/24/2025 documents, Resident resides at (Facility) as a long-term care resident. She is alert and oriented x1, she is dependent for mobility throughout the facility as well as a (mechanical lift) transfer. Resident can be impulsive at times; resident sustained a non-witnessed fall in the dining room. After the investigation of the events, the resident was restless in her chair and slid out of her (geriatric) chair. She was sent to the hospital and returned without admission to hospital. Diagnostics show a right clavicle fracture and 1st/2nd ribs with subtle acute fractures and UTI (urinary tract infection) Care plan reviewed and revised to meet resident needs. This is our final report. R2's Progress Notes, dated 11/26/2025 at 12:15 AM, Note Text: Resident returned to the facility. Resident transported to room, staff assisted residents into the bed and call light placed in reach. Resident seen in ER and treated for Un-witnessed fall, Abnormal CT-Scan, Closed FX (fracture) of multiple ribs on right side, Closed non-displaced Fx of right clavicle, Stercoral colitis, constipation and Acute UTI (urinary tract infection). Resident has new orders for ABT (antibiotics) from ER (emergency room). Discoloration noted to UE (upper extremity). Resident tearful during assessment and PRN (as needed) pain medication given for discomfort. On 12/3/2025 at 6:25 AM, V7, Certified Nursing Assistant (CNA), stated she usually works midnights. R2 fell in the dining room. I did not witness it but heard she had fallen but she passed away yesterday. If a resident falls, we are supposed to get help and tell the nurse. The nurse will then tell us what to do. I am not sure why (R2) was moved. On 12/4/2025 at 1:29 PM, V8, Certified Nursing Assistant (CNA), stated, If a resident falls, we are supposed to get help and tell the nurse before moving them because we could make it worse if we moved them and they were injured. On 12/4/2025 at 4:14 PM, V14, Licensed