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	08/16/2024

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview, observation, and record review, the facility failed to utilize physician ordered pressure relieving devices and or treatments for two of three residents (R3, R35) reviewed for pressure ulcers in the sample of 31. Findings Include: 1. R3's Minimum Data Set (MDS), dated [DATE], documents R3 is severely cognitively impaired. R3's MDS also documents need substantial to maximum assistance in rolling from left to right. R3's Braden Scale, dated 6/28/24, documents R3 has a moderate risk of developing pressure ulcers. R3's Physician Order Sheet (POS), dated 7/28/24, documents, (pressure Relieving boots) to bil (bilateral) feet when in bed, for sore heels. R3's Skin Care Plan intervention documents protect heels initiated on 2/28/24. On 08/13/24 at 2:20 PM, R3 was laying in bed and her heels were directly on the bed. On 8/15/24 at 2:20 PM while watching catheter care, R3 did not have on pressure relieving boots and her bilateral heels were red. R3's heels were lying flat on the bed. On 8/15/24 at 3:15 PM, V2, Director of Nursing, stated, She usually has the boots on, and they are in her room on her chair. V2 stated a standing order for skin prep would be initiated to R3's heels. 34964 2. R35's Face Sheet documents her diagnoses to include Multiple Sclerosis, Contractures of Bilateral Knees and Pressure Ulcer of Left Buttock. R35's Care Plan, dated 10/9/23, documents: SKIN: (R35) was admitted to the facility with actual skin complications r/t (related to) pressure injuries of the left buttock, left heel and right heel. She often refuses staff to turn and reposition her or will say she was already repositioned. She has a history of refusal of repositioning in another facility. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The goal for this care plan documents: Will remain free of further skin complications throughout next review. Interventions for this care plan include: Treatment as ordered to left buttock wound (admitted with) as per POS/TAR (Physician Order Sheet/Treatment Administration Record) until resolved. R35's Physician Order Summary Report, dated 8/15/24, documents the order dated 8/14/24: Cleanse area to left buttock with wound cleanser, apply collagen, calcium alginate, and bordered foam daily and prn (as needed). R35's Minimum Data Set (MDS), dated [DATE], documents R35 is alert and oriented. The assessment documents R35 has one unhealed unstageable pressure ulcer that was present on admission. R35's Wound Consultant report, dated 8/1/24, documents the measurements of her Stage 4 pressure ulcer as 3 cm by 2.5 cm by 0.2 cm with 100 % granulation. R35's Wound Consultant report, dated 8/8/24, documents her wound as a Stage 4 Pressure Ulcer that is improving with delayed wound closure. It documents the wound measurements as 1.6 centimeters (cm) by 2. 5 cm by 0.2 cm. It documents there is 100% granulation with periwound intact. On 8/13/24 at 3:24 PM, R35 stated she has a pressure ulcer on her upper right thigh that they have been treating for a while and stated it is getting better. On 8/15/24 at 4:40 AM, observed V17, Certified Nursing Assistant (CNA), and V19, CNA, provide incontinent care for R35. When turning R35 to her right side, there was a quarter sized pressure ulcer on her left ischium with no dressing on it. V17 checked the wet adult diaper that she had just removed and there was no old dressing in the diaper. V17 stated she was not sure if there was a treatment on the pressure ulcer when she changed R35 at about 2:45 AM. She stated she did not let the nurse know that there was not a treatment on R35's pressure ulcer. On 8/15/24 at 8:15 AM, V2, Director of Nursing (DON), V3, Registered Nurse /Minimum Data Set (MDS) Coordinator, and V22, Wound Nurse, provided pressure ulcer treatment for R35. V2 stated she did not know if the nurse was informed by the CNAs who took care of R35 this morning that her pressure ulcer dressing was not in place as ordered. She stated she did not know if the nurse did the treatment after R35 was changed. V2 stated if a CNA notices a treatment has fallen off of a resident's pressure ulcer they should inform the nurse so the treatment can be replaced so pressure ulcer is not exposed to urine and feces. When they rolled R35 to her side, there was still no dressing on her pressure ulcer on her left ischial pressure ulcer. V22 hand sanitized and donned gloves and cleansed the wound with wound cleanser. V22 then hand sanitized and donned gloves and applied a new treatment of collagen powder, calcium alginate, and bordered gauze to the wound. The wound was dry with dry edges with granulation and a large area of scar tissue noted around the wound. V3 stated the wound had gotten much smaller than when R35 was first admitted . The facility's Skin Management: Pressure Injury Treatment/General Wound Treatment policy, dated 4/2024, documents All Nursing Staff Responsible. Implement prevention protocol according to residents needs. Treatment Guidelines for stage 1 pressure injuries Do Not massage over bony prominence, Avoid the use of donut-type devices, consider applying a moisture barrier consider applying a transparent film or hydrocolloid dressing to protect fragile skin. Perform the Treatment as ordered using proper techniques of infection prevention and control.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947 Based on observation, interview, and record review, the facility failed to ensure progressive fall interventions were implemented for 2 of 6 residents (R1, R4) reviewed for falls in the sample of 31. Findings include: 1-R1's Face Sheet documents R1 was admitted to the facility on [DATE], with diagnoses including bipolar disorder, weakness, unsteadiness on feet, other abnormalities of gait and mobility, and tremor. R1's Minimum Data Set (MDS), dated [DATE], documented R1 was moderately cognitively impaired and ambulated with supervision. R1's Care Plan, initiated 7/17/20, documents R1 is at risk for falls related to balance issues, tremors, marching gait, osteoporosis, and psychoactive drug use. R1's Fall Risk Assessment, dated 6/27/24, documents R1 is at high risk for falls. The Facility's Incident Log documents R1 had falls on 11/20/23, 1/1/24, 2/19/24, 2/20/24, 2/21/24, 3/1/24, and 6/19/24. R1's 2/19/24 Fall Investigation documents R1 lost her balance and fell when trying to use the restroom. The fall intervention added was therapy evaluation. On 8/15/24 at 1:00 PM, V4, Administrator in Training (AIT), stated she checked with the Therapy Department, and no evaluation was completed for R1's 2/19/24 fall intervention. 2-R4's Face Sheet documents R4 was admitted to the facility on [DATE], with diagnoses including respiratory failure, type 2 diabetes mellitus, unsteadiness on feet, and weakness. R4's MDS, dated [DATE], documented R4 was severely cognitively impaired and dependent for transfers. R4's Care Plan, initiated 7/20/20, documents R4 is at high risk for falls due to needing extensive assistance with ADL's (Activities of Daily Living), having a history of falls, and taking medications that could have adverse reactions after falls. R4's Fall Risk Evaluation, dated 7/9/24, documents R4 is at high risk for falls. The Facility's Incident Log documents R4 had falls on 4/6/24 and 6/9/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's 4/6/24 Fall Investigation documents V28, Licensed Practical Nurse (LPN), was called to R4's room where V27, CNA, was attempting to transfer R4 from the bed to wheelchair by herself. V27 stated R4 was not pivoting and was unable to hold her up, so she had to lower her to the floor. The Root Cause was determined to be V27 was attempting a one person transfer that should have been a mechanical lift transfer. (R4's MDS dated [DATE] documents R4 was dependent for transfer.) R4's 6/9/24 Fall Report documents R4 was yelling for help and was found sitting on her buttocks in her room. R4 was sent to the emergency room (ER) for evaluation and was found to have a fracture. The Root Cause was determined to be R4 self-transferred when she should be a mechanical lift transfer with maximal assistance. The progressive fall interventions added included keeping R4's bed in the lowest position and adding a floor mat to the open side of her bed. On 8/14/24 at 4:00 PM, R4 was sleeping in bed in her room. The right side of R4's bed was pushed against the wall, and there was a bedside table to R4's left side. There was no floor mat on the open (left) side of her bed, and the bed was raised to standard height. On 8/14/24 at 4:13 PM, V21, Licensed Practical Nurse/LPN, stated R4 is a fall risk, but was unsure of her specific fall interventions. V21 reviewed R4's Care Plan, then entered R4's room, lowered her bed, and stated she would place a floor mat in her room right away. On 8/14/24 at 4:17 PM, V20, CNA, stated she has been working with R4 in the facility for a few months and was not aware she was a fall risk. V20 stated she had never seen any floor mats in R4's room. On 8/16/24 at 12:15 PM, V4, Administrator in Training (AIT), stated she expects progressive fall interventions to remain in place unless discontinued. The Facility's Fall Prevention and Management Policy, reviewed 9/2023, documents, This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe and environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Facility Guideline following a fall incident: Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.