

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Bria of Geneva		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 East State Street Geneva, IL 60134	
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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 35541 Based on observation, interview and record review the facility failed to provide ongoing monitoring and assessments for the use of a resident's wheelchair seatbelt/physical device. This failure applies to 1 of 1 (R12) residents reviewed for physical restraints in the sample of 19. The findings include: On 6/26/24 at 10:37 AM, R12 was seated in a wheelchair by the front desk of the facility. A seatbelt, attached to R12's wheelchair, was clasped securely around R12's waist. When R12 was asked about the seatbelt, R12 stated, I have had it for awhile. On 6/26/24, R12's electronic medical records dated June 2023-June 2024 were reviewed. R12's current care plan showed R12 had a diagnosis of cerebral palsy with contractures to her bilateral lower extremities and right hand. The care plan showed R12 required staff assistance for all activities of daily living. The care plan showed R12 used a seatbelt while in her wheelchair but showed no documentation as to the medical need for the R12's seatbelt. R12's electronic medical records showed no facility restraint or seatbelt assessments for R12. R12's June 2024 (physician) Order Summary report showed no physician order for R12's seatbelt or documented medical need for R12's belt. On 6/26/24 at 10:49 AM, V2 Director of Nursing stated she was not aware R12 used a seatbelt while in her wheelchair. V2 stated she did not know the reason as to why R12 used the belt. On 6/26/24 at 11:53 AM, V20 Certified Nursing Assistant (CNA) stated, (R12) is dependent on us for everything. She is a hoier (mechanical lift) transfer. She doesn't move on her own. She doesn't try to get out of her wheelchair on her own. She likes to sit in her wheelchair. She can sit up on her own in it. She doesn't have seizures or sudden (body) movements. (R12) has had the seatbelt on her wheelchair for a long time, for years. I don't know why she has it other than she just wants it. She screams at us if we don't clasp it in place. V20 stated R12 is able to release the belt but is unable to re-clasp/secure the belt in place. On 6/26/24 at 11:43 AM V1 Administrator stated the facility had not done any restraint assessments or assessments of R12's wheelchair seatbelt in the last year. V1 stated, We can't find any assessments of (R12's) seatbelt. Our restorative nurse would be responsible for assessing (R12's) seatbelt use but I just spoke with him (restorative nurse) and he said he didn't know he was responsible for assessing that. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 12:02 PM, V19 Restorative Nurse stated any type of resident restraint device is to be reviewed and assessed quarterly to see if the resident still needs to use the device. V19 stated he was new to the position as the restorative nurse and didn't realize he was responsible for R12's seatbelt/physical device assessments. When V19 was asked why R12 needed a seatbelt on her wheelchair, V19 stated, She has had the seatbelt for awhile but was always able to undo it. I believe it is because of her cerebral palsy. She used to have spastic-type movements related to her cerebral palsy but doesn't have those anymore. The facility's Physical Restraint/Device policy dated 10/2021 showed, A Physical Device Observation will be completed by the Restorative Nurse if there is a possibility that a physical device may be considered a restraint . The physical device will be reassessed at least quarterly or with any significant change by the Restorative Nurse .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35541 Based on observation, interview and record review the facility failed to provide ADL (Activities of Daily Living) assistance to residents that require staff assistance for toileting/incontinence care for 3 of 19 residents (R12, R64, R53) reviewed for ADLs in the sample of 19. The findings include: 1. R12's current care plan showed R12 was completely dependent on staff for incontinence care related to her diagnosis of cerebral palsy. R12 was incontinent of bowel and bladder. The care plan showed, Keep resident clean and dry after each incontinent episode. On 6/24/24 at 8:57 AM and 9:30 AM, R12 was observed sleeping in a wheelchair in the television (TV) area of the facility's memory care unit. On 6/24/24 at 9:40 AM, V4 and V5 Certified Nursing Assistants (CNA) propelled R12 into her room to provide cares. As V4 and V5 transferred R12 into bed, R12 began scratching at her incontinence brief and stated itchy. V5 CNA was asked when R12 was last provided with incontinence care, V5 stated, Around 6 AM, when I got her out of bed. V4 and V5 removed R12's incontinence brief soiled with a large amount of urine. A continuous red, raised rash was noted to R12's buttocks, vaginal area, and down R12's inner thighs. Several creases were noted to the skin of R12's buttocks from R12's wet incontinence brief. As V4 and V5 provided R12 with incontinence care, R12 attempted to scratch the rash to her buttocks, multiple times, while saying itchy repetitively. 2. R64's current care plan showed R64 required staff assistance for toileting related to his diagnosis of dementia. The plan showed, Resident is to be taken to the bathroom every two (hours). R64 was incontinent of bowel and bladder. On 6/24/24 at 8:57 AM, 9:30 AM, and 10:07 AM, R64 was observed sitting in wheelchair by the television on the memory care unit of the facility. On 6/24/24 at 10:53 AM, V4 CNA wheeled R64 into the bathroom. As R64 stood by the toilet and V4 CNA began to unclasp R64's incontinence brief, R64's brief dropped to his knees due to the weight of his brief. R64's brief was saturated with dark yellow urine. R64's buttocks appeared red. V4 CNA stated she had last toileted R64 at 7:00 AM that morning. 3. R53's current care plan showed R53 was dependent on staff for toileting/incontinence care related to his diagnosis of dementia. R53 was incontinent of bowel and bladder. On 6/24/24 at 8:57 AM and 9:50 AM, R53 was observed sitting in a wheelchair by the television on the memory care unit of the facility. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/24 at 10:00 AM, R53 was taken to his room by V4 and V5 CNA(s) for cares. V4 and V5 transferred R53 into bed and removed R53's incontinence brief. A large amount of urine was noted in the brief. Multiple skin creases were noted to R53's buttocks. A small nickel-sized, red, open area was noted to R53's inner right buttock. V4 CNA stated the open area to R53's buttock was new for him I think. V4 stated she last provided incontinence care to R53 before breakfast, around 7-7:30 AM. On 6/25/24 at 9:24 AM, V10 Wound Nurse stated incontinence care is to be provided, to residents that require staff assistance, every two hours and as needed.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35541 Based on observation, interview and record review the facility failed to provide the necessary treatments for a resident's rash and for residents with leg edema. These failures apply to 3 of 19 residents (R12, R15, R64) reviewed for necessary care and services in the sample of 19. The findings include: 1. R12's current care plan showed R12 was completely dependent on staff for incontinence care related to her diagnosis of cerebral palsy. R12 was incontinent of bowel and bladder. The care plan showed, Keep resident clean and dry after each incontinent episode. R12's Skin and Wound Note dated 6/20/24 showed R12 had a MASD (moisture associated skin damage) fungal rash to her buttocks. The note showed, The patient is at increased risk for developing skin breakdown and moisture associated skin damage due to fecal and urinary incontinence, obesity, inability to perform self-care. On 6/24/24 at 8:57 AM and 9:30 AM, R12 was observed sleeping in a wheelchair in the television (TV) area of the facility's memory care unit. On 6/24/24 at 9:40 AM, V4 and V5 Certified Nursing Assistants (CNA) propelled R12 into her room to provide cares. As V4 and V5 transferred R12 into bed, R12 began scratching at her incontinence brief and stated itchy. V5 CNA was asked when R12 was last provided with incontinence care, V5 stated, Around 6 AM, when I got her out of bed. V4 and V5 removed R12's incontinence brief soiled with a large amount of urine. A continuous red, raised rash was noted to R12's buttocks, vaginal area, and down R12's inner thighs. Several creases were noted to the skin of R12's buttocks from R12's wet incontinence brief. As V4 and V5 provided R12 with incontinence care, R12 attempted to scratch the rash to her buttocks, multiple times, while saying itchy repetitively. On 6/25/24 at 9:33 AM, V10 Wound Nurse stated R12 was currently being treated for a fungal rash to her buttocks. V10 stated, Her rash can get worse if she is sitting in a wet brief for too long. She needs to be changed (incontinence care) every two hours . The facility's Skin Management policy dated 6/2023, The following treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used . Moisture: avoid prolonged periods of wetness . 2. R15's physician order dated 6/13/24 showed staff were to apply TED hose (compression stockings) to R15's legs, one time a day, related to R15's leg edema; remove hose at night. R15's Vascular Consult Visit Summary note dated 6/20/24 showed R15 had pitting edema to both of his feet related to his diagnoses of peripheral arterial disease and superficial venous disease to his lower extremities. The note showed, Plan of Care . Continue compression therapy . (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/24 at 2:07 PM, R15 was seated in his wheelchair. No compression stockings were noted to R15's lower extremities. R15 wore socks on his feet with leg edema bulging over the top of the socks on both feet. On 6/25/24 at 9:19 AM, R15 was seated in his wheelchair. No compression stockings were noted to R15's lower extremities. Edema was noted to both of R15's lower legs. On 6/25/24 at 9:38 AM, V10 Wound Nurse stated, (R15) is supposed to wear TED hose because of his edema and his history of congestive heart failure. 3. R64's physician order dated 5/31/24 showed, Please ensure patient is wearing compression stockings! R64's Vascular Consult Visit Summary note dated 6/20/24 showed R64 had a vascular foot ulcer and edema to both of his lower legs related to his diagnoses of peripheral artery disease, Type 2 Diabetes Mellitus, and a history of deep vein thrombus to his lower extremities. The note showed, Plan of Care . Continue compression therapy . On 6/24/24 at 8:57 AM, R64 was seated in his wheelchair. R64 wore shoes and socks on both feet. No compression dressings were noted to R64's legs. Edema was noted to R64's right lower leg, bulging over the top of his sock. On 6/24/24 at 12:30 PM, R64 was seated in his wheelchair. No compression dressings were noted to R64's legs. On 6/25/24 at 9:33 AM, V10 Wound Nurse stated, (R64) was recently seen by our vascular consultants. His left ankle wound is a full-thickness, vascular wound. He is to wear compression wraps, to both of legs, during the day to help treat his edema and vascular disease.		

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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** 35541 Based on observation, interview and record review the facility failed to implement pressure relieving interventions for a resident at risk for pressure injuries and recently diagnosed with a new sacral injury for 1 of 4 residents (R29) reviewed for pressure injuries in the sample of 19. The findings include: R29's current care plan showed R29 was at risk for skin complications related to her diagnoses of dementia and incontinence. R29's Braden Scale for Predicting Pressure Sore Risk dated 5/19/24 showed R29 was at high risk for developing pressure injuries. A Skin Condition assessment dated [DATE] showed R29 had developed new redness and skin discoloration to both of her buttocks. The note showed, Orders . Resident to be re-positioned every two hours. Low air (loss) mattress to be provided per DON (Director of Nursing). On 6/24/24 at 9:18 AM, R29 was in bed, lying on a standard, hospital-type mattress. On 6/24/24 at 9:22 AM, V5 Certified Nursing Assistant (CNA) provided incontinence care to R29. A large, irregular-shaped, reddened area was noted across R29's sacrum with a dime-sized, open purplish wound noted to her left buttock. V5 stated. (R29) is on a regular mattress. Our low air loss mattresses are connected to a pump that we turn on and off. On 6/24/24 at 10:35 AM, R29 remained in bed, lying on a standard mattress. On 6/25/24 at 9:24 AM, V10 Wound Nurse stated she was not notified of R29's new skin condition found on 6/21/24. V10 stated staff are to notify her, V2 DON, the physician and the resident's family as soon as a new skin condition is found. V10 reviewed R29's Skin Condition assessment dated [DATE]. V10 stated, I see (R29) has a new wound condition. I was not aware of this. Looks like she has a new discoloration to her buttocks. I was not notified she needed a low air loss mattress. It says the DON (V2) was aware of that. I know (R29) doesn't have a low air loss mattress. Myself or hospice should have been notified right away she needed the mattress so there was no delay in getting it. That's not good. That's why I should have been notified so I could have assessed her and put treatments into place . The facility's Skin Management: Pressure Injury Treatment policy dated 6/2023 showed, The following treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used . Guidelines: Implement prevention protocol according to resident needs . Mobility: turn every two hours, reposition in chair every two hours, provide appropriate pressure reducing devices .		

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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** 35541 Based on observation, interview and record review the facility failed to supervise a dementia resident, with a history of wandering behaviors, in a manner to prevent the resident from eloping from the facility. The facility failed to ensure oxygen tanks were safely secured in place. These failures apply to 2 of 19 residents (R29, R16) reviewed for safety and supervision in the sample of 19. The findings include: 1. R29's admission record showed R29 was admitted to the facility on [DATE] with a diagnosis of dementia. R29's Elopement Evaluations dated 1/5/24 and 2/6/24 showed R29 was at a high risk for elopement due to R29's impaired cognition, physical ability to leave the building, wandering around the facility, and R29 exhibiting behaviors of actively trying to exit the facility. R29's Behavior Note dated 1/28/24 showed R29 tried twice to get into the elevator but was stopped by staff. R29's Behavior Note dated 2/4/24 showed R29 was agitated and wanted to go out of the facility, resident is continuously seeking exit . R29's Behavior Note dated 2/5/24 showed, Resident was still agitated and still adamant on leaving the facility stating the she needs to go to the airport and go back to Italy because the secret service is after her . R29's Behavior Note dated 2/6/24 at 9:02 PM showed R29 was found outside of the facility, in the facility's parking lot, attempting to get into a locked car saying she needs to go to the airport . A nursing note for R29 dated 2/22/24 showed R29 was moved to a secured memory care unit in the facility. On 6/25/24 at 11:33 AM, V7 Certified Nursing Assistant (CNA) stated on 2/6/24, when she arrived at the facility to work, she saw R29 propelling herself in a wheelchair around the front parking lot. V7 stated, I was pulling into work when I noticed (R29) propelling herself around the parking lot, going from car to car. She seemed anxious and upset so I got out of my car and walked up to her. She kept saying she was trying to leave. I just kind of walked with her for a bit. I was finally able to her inside the building within about ten minutes. It seems she somehow got past the front desk. I had never taken care of her before. I didn't know her but she looked confused and out of place so I went up to her. I was not aware she was an elopement risk . V7 stated R29 sustained no falls or injuries during the incident. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 11:39 AM, V8 Registered Nurse (RN) stated on 2/6/24 she was the nurse on duty at the time of R29's incident. V8 stated, I didn't see (R29) leave. I was made aware of the incident when staff brought her back inside the building. She had gotten out to the parking lot through the front door. She somehow got past reception. I know she had dementia and was confused. I did not know she was an elopement risk . On 6/25/24 at 12:52 PM, V1 Administrator stated he was unable to find a facility incident report and/or an investigation report into the incident involving R29 on 2/6/29. V1 stated he was out on a leave of absence the entire month of February 2024 and there was a previous employee acting as the administrator in his absence. V1 stated, Prior to today, I did not know (R29) had gotten out to the parking lot. Had I been here when it happened, I would have done a thorough investigation . There is an elopement binder, that is kept at the front desk, that identifies which residents are at risk for elopement. (R29) is listed in the binder. I don't know who the receptionist was at the time of the incident. I don't have the exact time the incident happened but the expectation is that the receptionist and staff are monitoring who is going in and out of the building. The facility's Elopement and Unsafe Wandering Prevention and Management Program policy (undated) showed, Our mission is to provide compassionate care and service, to maintain the safety of our residents, and maximize each resident's physical, mental, and psychosocial well-being . The policy showed, The purpose of our Elopement and Unsafe Wandering Prevention and Management Program is to provide our residents with an interdisciplinary approach to identify the risk of elopement and unsafe wandering . A list of residents identified as at risk for elopement is maintained and updated to remain accurate and current . Staff can identify the presence of residents at risk at the beginning and end of the shift and periodically throughout the shift . 35174 2. R16's Facesheet dated 6/26/24 showed R16 is a [AGE] year old female admitted to the facility on [DATE] with diagnoses which include: unspecified bronchus/lung neoplasm, history of COVID-19, and Bronchiectasis (airway damage). On 6/24/24 at 10:20 AM, R16 stated she uses oxygen at night if she feels short of breath. R16 pointed at the oxygen concentrator next R16's bed. R16 stated she used to use oxygen tanks when she would leave her room and needed oxygen. R16 pointed to an unsecured oxygen tank leaning against R16 small dresser. On 6/24/24 at 10:25 AM, R85 (R16's roommate) stated R16 had not used the oxygen tanks in a long time. R85 stated the oxygen tank against the dresser had been there at least 2 weeks. On 6/26/24 at 11:50 AM, V21 (CNA) stated oxygen tanks need to be in a cart or holder. V21 stated we can let the nurse know and they can open the door to the oxygen tank room. On 6/24/24 at 12:30 PM V2 Director of Nursing stated unsecured oxygen tanks are a hazard. Oxygen tanks need to be in a holder or stored in the oxygen room. V2 opened the oxygen tank storage room. The tank room had 2 tank racks with multiple open slots available. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Oxygen Storage Policy dated 12/2018 showed the policy is for the standards for the safe handling of oxygen storage to ensure safety is met, oxygen tanks should be stored in storage areas, and oxygen cylinders must be protected from mechanical shock, falling objects, and other tank hazards.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on observation, interview, and record review the facility failed to ensure medications were administered per standards of practice which applies to 1 of 19 residents (R28) reviewed for medication services in a sample of 19. The findings include: R28's Facesheet printed on 6/26/24 showed R28 is an [AGE] year old male admitted to the facility with diagnoses which include: essential hypertension and heart failure. R28's Order Summary printed on 6/26/24 showed R28 has an order for Metoprolol Succinate ER 25 milligram (mg) tablet related to essential hypertension. On 6/24/24 at 10:25 AM, R28 was lying in bed watching television. R28 had a white oval pill on his chest. The pill had 564 stamped into the pill. The pill was dry and intact. R28 stated the nurse was in about 9 AM with his medications. On 6/24/24 at 10:35 AM, V17 Licensed Practical Nurse (LPN) identified the pill as R28's Metoprolol ER 25 mg dose. V17 stated she thought he took them all. V17 stated R28's medications were given to him about 9 AM. On 6/24/24 at 12:30 PM, V2 Director of Nursing stated when a nurse administers medications they need to go through the rights (resident, med, time, etc) for medications, and make sure the resident takes all of the medications. The facility's medication administration policy dated 3/2023 showed to remain with the resident to ensure that the resident swallow the medication.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35178 Based on interview and record review the facility failed to provide R22 with informed consent for psychotropic medication for 1 of 5 residents (R22) reviewed for unnecessary medication in the sample of 19. The finding include: R22's Physicians Orders on 06/25/2024 shows, sertraline hydrochloride Oral Tablet 25 milligrams. Give 1 tablet by mouth one time a day related to major depressive disorder, single episode, unspecified. On 06/26/24 at 12:42 PM, V3 ADON-Assistant Director of Nursing said, R22 was started on sertraline hydrochloride in January (2024). There was no consent. R22's Psychiatry Note dated 01/26/2024 shows, R22 has multiple diagnosis including amnesia. Unspecified dementia, unspecified severity, without behaviors/psychosis/mood/anxiety. Major Depressive disorder, single episode, unspecified. The facility did not provide a policy for Psychotropic Medication use when requested during the survey.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146067	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Bria of Geneva		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 East State Street Geneva, IL 60134	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34117 Based on observation, interview and record review the facility failed to ensure dietary staff wore beard guards during food handling and failed to ensure food was covered to prevent contamination. This applies to all residents residing in the facility reviewed for food sanitation. The findings include: The facility's resident census provided on 6/24/24 shows 95 residents residing in the facility. On 6/24/24 during initial tour of the kitchen a full tray of mandarin oranges each placed in a serving bowl were in the fridge uncovered. At 11:40 AM, the food cart was in the downstairs dining room. The tray of mandarin oranges were not covered with the food cart open. At 12:04 PM, during the noon meal on the first floor dining room, V14 (dietary staff) was at the steam table plating the noon meal. A patch of outgrown hair was on the middle of V14's chin without a beard guard on. V15 (Dietary Staff) was preparing jelly sandwiches. V15's facial hair beard was outgrown with medium stubble, he was not wearing a beard guard. V13 (Dietary Staff) was in the kitchen cutting watermelon. He had a full thick facial beard without wearing a beard guard. V12 (Interim Dietary Manager) was in the kitchen helping with lunch service, he was placing meal trays in the food cart. V12 had a thin layer of facial hair without wearing a beard guard. On 6/25/24 at 8:52 AM, V12 said the male staff were not wearing beard guards yesterday and should have been. Food should be covered when stored in the fridge and during transport to prevent contamination. The Facility's undated [NAME] Guard and Hair Restraint Policy states, [NAME] Guards: Food handlers with beards may be required to wear a beard cover, especially if their beard is long. This helps minimize the likelihood of hair contamination in the food service industry. The Facility's Food Storage Policy revised 2023, states, All foods will be stored wrapped or in covered containers, labeled, dated, and arranged in a manner to prevent cross contamination.		