(X6) DATE

Illinois Department of Public Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SIDENTIFICATION NUMBER: A RUM DING.					
			A. BUILDING:		С	
		IL6001028	B. WING			, 1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELMA /, IL 62035	AR		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga	ation 2344998/IL161037				
S9999	Final Observations		S9999			
	Statment of Licensu	ure Violations:				
	300.610 a) 300.1210 b) 300.1220 b)2) 300.1220 b)3) 300.3210 o)					
	a) The facility procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conforming and othe policies shall compositive written policies the facility and shall	dvisory physician or the ommittee, and representatives in services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Nursing and Person b) The facility care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	shall provide the necessary of attain or maintain the highest l, mental, and psychological sident, in accordance with apprehensive resident care l properly supervised nursing care shall be provided to each e total nursing and personal				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/21/23 **Electronically Signed** 

TITLE

	epartment of Fublic		0.00 1	F CONCERNATION		OLIDA (E) (
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, " I L'AIN	J. JOHNEOHOW	ISERTI IO/TION HOWIDER.	A. BUILDING:	A. BUILDING:		
					c	;
		IL6001028	B. WING		07/1	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		1623 29 W	EST DELMA	AR		
BRIA OF	GODFREY	GODFREY	r, IL 62035			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	Services b) The DON sinursing services of 2) Oversed assessment of the include medically defunctional status, se impairments, nutritic psychosocial status condition, activities potential, cognitive 3) Develop care plan for each resident's compreheneds and goals to orders, and personal Personnel, represenursing, activities, of modalities as are of be involved in the plan. The plan shareviewed and modifineeded as indicated The plan shall be remonths.  Section 300.3210 (o) The facility sthe resident's family conservator, and arfinancially responsil whenever unusual of accidents, sudden if absences, extraord	onal status and requirements, discharge potential, dental potential, rehabilitation status, and drug therapy. Sing an up-to-date resident resident based on the ensive assessment, individual be accomplished, physician's all care and nursing needs. Inting other services such as dietary, and such other redered by the physician, shall reparation of the resident care all be in writing and shall be fied in keeping with the care diet by the resident's condition.				
	These requirements	s are not met as evidenced by:				

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CB0211 If continuation sheet 2 of 11

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6001028	B. WING		07/1	1/2023
NAME OF PROVIDER (	OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF GODFRE	Υ		/EST DELM/ /, IL 62035	AR		
PREFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
Based of failed to interven notify the weight lenutrition R2 sust (24.51%)  Findings  R2's Fauthe facil  R2's Apredocumed diabetes hypertered disturbated acute king R2's Care (R2) is constinuity of the pounds. Hyperted constinuity of the pounds of the po	monitor an tions to pre e Dietician oss for 1 of in the sam aining a 51-o) from 2/10 s include:  ce Sheet do ity on 9/10/2 ogress Note of the sam and sheet of all measures. She is a ser needs known and cation	and record review, the facility d implement nutritional vent weight loss and failed to and family of a significant 3 residents (R2) reviewed for ple of 8. This failure resulted in pound (lbs.) weight loss 1/23 through 3/24/23.  Decuments she was admitted to 2020.  And and 1/16/2023 at 4:35 PM, and contact isolation for being an Order Sheet (POS) ses of dementia, type 2 ithout complications, chizophrenia, psychotic disturbance and anxiety, and	S9999			

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Illinois D	epartment of Public	Health				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
						:
		IL6001028	B. WING			1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DESS CITY S	STATE, ZIP CODE		
NAIVIL OF I	-NOVIDEN ON SUFFEIEN		/EST DELM			
BRIA OF	GODFREY		7. IL 62035	AIK		
040.15	CLIMMA DV CTA			DDOVIDEDIC DI ANI OF CORDECTI		0.(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEI ICIENCI)		
S9999	Continued From pa	ge 3	S9999			
	P2's Care Plan und	ated documents, "She is at				
		Itercation in skin integrity				
	related to, diabetes. Currently skin is intact. (R2) was admitted to facility from hospital. She has					
	long term memory I	oss and has makes				
		e is going home next week,				
		y. She has a diagnosis of				
		order, depression, type cause usband, she is pleasant and				
		int with care. She is able to				
		o use wheelchair and pre pale				
		staff she cannot walk. Her				
		visit often which can upset her.				
		xperienced unplanned weight				
		te illness, hospitalization, lack				
		R2) will not have further weight Monitor weights weekly,				
		abs." R2's Care Plan does not				
		or intervention for her				
	diagnosis of diabete					
		tals Summary Report				
		0/22, R2 weighed 208 pounds				
	(lbs.).					
	R2's Dietary Nutrition	on at Risk Form Initial visit,				
		12:56 PM, documented				
		ng for weight gain. Recently				
		1/2022 203.5 pounds. 9/7/2022				
	•	period of weight loss, now				
	with gain."					
	R2's Dietary Nutritio	on at Risk Form Initial visit,				
		1:00 PM, documented				
		ing for weight gain, Recently				
	COVID positive. 2/1	10/2023 208 had period of				
		th gain. Continue Regular diet				
	and weekly weight	monitoring. Will follow."				

R2's Weight and Vitals Summary Report

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:				LETED
			D MINIO		c	
		IL6001028	B. WING		07/1	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELM/ /, IL 62035	AR		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
		veight on 3/2/2023 at 11:34 ds. This was 39 lbs. weight or 18.75%.				
	dated 3/3/2023 at 1 triggering for weight positive and started Had period of weight up to 7 regular (sodup. Plan to start end meals. Continue regmonitoring. Will follows:	on at Risk Form Initial visit, 2:12 PM, "Resident is t gain, Recently COVID I eating all meals in her room. In t loss, now with gain. Drinks Ia)/day and doesn't want to get couraged to dining room with gular diet and weekly weight ow." This form did not address ted in the Weight and Vital				
	dated 3/10/2023 at request re-weigh). I started eating all mo 7 regular (soda)/day Plan to start encour	on at Risk Form Initial visit, 11:48 AM, "169 pounds (will Recently COVID positive and eals in her room. Drinks up to y and doesn't want to get up. raged to dining room with gular diet and weekly weight				
	documented R2 cor	tals Summary Report ntinued to lose weight and on PM, R2's weight was 3.2 pounds.				
	dated 3/17/2023, "1 positive and started Drinks up to 7 regul want to get up. Plar room with meals. H any recent blood glu	on at Risk Form Initial visit, 69 pounds. Recently COVID I eating all meals in her room. Iar (soda)/day and doesn't in to start encouraged to dining istory of diabetes. Did not find ucose levels or A1C, Rec to may be due to uncontrolled ollow."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6001028	B. WING		l l	C <b>11/2023</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
BRIA OF	GODFREY		WEST DELMA	R		
	I		Y, IL 62035			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	3/24/2023 at 2:30 P 157 pounds. This w loss from 2/10/23 to					
	dated 3/24/2023, "1 positive and started Drinks up to 7 regul want to get up. Plar room with meals. H any recent blood glu	on at Risk Form Initial visit, 57 pounds. Recently COVID eating all meals in her room. ar (soda)/day and doesn't in to start encouraged to dining istory of diabetes. Did not find ucose levels or A1C, Record ss may be due to uncontrolled ollow."				
	AM, Late Entry: Not "SSD, (Social Servi discuss her decline She stated that she she missed her fam that her daughter or SSD asked (R2) if sid dressed and come (R2) is experiencing depression symptomeals and activities address her isolation both. SSD told her to Monday to see if she	s, dated 3/24/2023 at 11:23 te Text: Psychosocial Note ce Director), Met with (R2) to in weight and overall health. was not depressed howeverally and husband. She stated omes to visit her all the time. She would like to get up, get to activities, she stated no. It is major isolation and ms. She has been refusing to mand depression she denies that we would follow up to is doing better."				
	documents, "Reside throughout shift tod breakfast and lunch Nursing and Social Resident continues resident she should when refusing meal	, dated 3/24/2023 at 1:14 PM, ent has refused meals ay. Resident refused in DON and SS, (Director of Service Director), aware, to feel nauseated. Informed try to eat, education provided is." R2's Note does not can or family member was				

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IIIIIIOIS L	epartment of Public	nealth	1		т	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		LETED
		IL6001028	B. WING		1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			VEST DELMA	,		
BRIA OF	GODFREY		Y, IL 62035			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				22.10.2.10.7		
S9999	Continued From pa	ge 6	S9999			
	contacted regarding	g R2 refusing meals.				
		, dated 3/24/2023 at 2:13 PM,				
		ext NP aware of refusal of				
		ion. New Order for CBC				
		ount), UA (urinalysis) C/S vity) and Psych referral."				
	(culture and sensiti	vity) and i sychileterial.				
	R2's Nurse's Notes	, dated 3/27/2023 at 11:54				
		Weight Warning, Value 157.0				
		je over 30 days; -10.0%				
		ays, RD, MD, resident/family				
	aware."					
	R2's Nursa's Notas	, dated 3/27/2023 at 2:11 PM,				
		efused all meals and most				
		hout shift. (R2) was educated				
		of eating and taking her				
		nt continues to refuse." R2's				
		s not document the Doctor of				
		acted regarding R2 refusing to				
	eat or take her med	dication.				
	R2's Comprehensiv	ve Metabolic Panel Lab Report				
	'	3/27/2023 at 9:45 AM				
		2's albumin level was 3.2				
	(normal 3.5-5.5 g/d	I).				
	DOI: Nome to Not	d-t- d 0/00/0000 at 0 00 454				
		, dated 3/28/2023 at 6:28 AM,				
		hospital) about 11:30 AM. tted to hospital for UTI,				
		on), and N/V, (Nausea and				
	vomiting)."	on,, and it, v, (itadood and				
	<b>O</b> ,					
		dated 3/30/23, documented				
		to the facility with diagnoses				
	of Pyelonephritis.					
	R2's Dietary Mutritic	on at Risk Form Initial visit,				
		1:35 PM, "Recently COVID				

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IL 6001028    B. WING	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  BRIA OF GODFREY  1623 29 WEST DELMAR GODFREY, IL 62035    CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PREFIX   TAG   PREFIX   TAG   PREFIX   TAG   PREFIX   TAG   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX   TAG   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PROVIDE				A. BUILDING:		C	
BRIA OF GODFREY   1623 29 WEST DELMAR GODFREY, IL. 62035			IL6001028	B. WING		07/1	1/2023
CALL	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
System   Symmetry Statement of periodencies   December   Provincies	BRIA OF	GODFREY			AR		
positive and started eating all meals in her room. Hospitalized last week 2/2 (secondary to) UTI, (urinary tract infection), N/V (nausea/vomiting). PICC (peripherally inserted central catheter) and antibiotics, refusing meals and medication. NP, (Nurse Practitioner), aware, will add sugar free health shakes with meals. Continue to encourage by mouth intake."  R2's Care Plan was not updated after January 2023 and does not reflect her refusing meals, or weight loss.  R2's April 2023 Physician Order Sheet (POS) documents diagnoses of dementia, type 2 diabets mellitus without complications, hypertension and schizophrenia, psychotic disturbance, mood disturbance and anxiety, and acute kidney failure. R2's POS documents she is on a regular texture diet, thin liquids consistency, and sugar free health shakes three times day; Blood glucose per finger stick as needed for signs/symptoms if hyperglycemia/hypoglycemia. The POS also documents R2 has an order for Glucophage tablet 1000 milligrams (MG), give 1 tablet by mouth two times a day related to type 2 diabetes mellitus without complications; Sitagliptin phosphate tablet 100 mg, give 1 tablet one a day for diabetes; and Trulicity Solution Pen Injector. 75 MG/O.5 ML (dulaglutide) inject 1 applicatorful subcutaneously one time a day every Monday related to type 2 diabetes mellitus without complications.  No other Dietary Nutrition at Risk Form was provided by the facility after 3/31/2023. R2 left the facility on 4/16/2023. No Dietary Forms were	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
On 7/6/2023 at 2:34 PM, V17, Corporate	S9999	positive and started Hospitalized last we (urinary tract infecting PICC (peripherally antibiotics, refusing (Nurse Practitioner) health shakes with by mouth intake."  R2's Care Plan was 2023 and does not weight loss.  R2's April 2023 Phydocuments diagnost diabetes mellitus whypertension and sidisturbance, mood acute kidney failure on a regular texture and sugar free heal Blood glucose per find signs/symptoms if the POS also documents diabete to mouth two diabetes mellitus which signs/symptoms if the POS also documents diabeted by mouth two diabetes mellitus which significant for the post of the post	I eating all meals in her room.  Rek 2/2 (secondary to) UTI, on), N/V (nausea/vomiting).  Inserted central catheter) and meals and medication. NP, on, aware, will add sugar free meals. Continue to encourage  I not updated after January reflect her refusing meals, or  I sician Order Sheet (POS) ones of dementia, type 2 one of dementia, type 2 one of dementia, psychotic disturbance and anxiety, and one of the complications, one of the complications one of the complications one of the complications; one of the complications; one of the complications of the complication	S9999			

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI	E CONSTRUCTION	(X3) D∆T⊏	SLIRVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			, a DOILDING.		_	<u> </u>
İ		IL6001028	B. WING		07/1	; 1/2023
					1 07/1	1/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BRIA OF	GODFREY		'EST DELM <i>!</i> ', IL 62035	<b>AR</b>		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
	Dietary Notes we had in the middle of rep (V17), but I will have R2's Nurse's Note of was sent to hopsita  On 6/23/2023 at 4:00 Attorney), for R2 standifficult for me becamom was declining never contacted me my mom was not earney mom was not earneyer told me she with the she was not earneyer told me she with the nursing home juchange in behavior my heart seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the feel like if they just we will have the seeing the seein	atted, "These are all of the ave on (R2). I know we were lacing our former Dietician e to get back to you."  dated 4/16/23 documented R2 I for change of condition.  O4 PM, V7, POA, (Power of atted, "This has been very use I had no idea that my in health, and the facility e, just once to let me know that ating. If I would have known, I ere and got her to eat. They was refusing medications or atting. Nobody told me that, and ust told me my mom had a and her mental state. It broke e decline in my mom's health. I would have reached out to me				
	On 6/30/2023 at 3:3 (DON), stated, "(R2 she started staying refusing medication sicker and sicker. It since February. (R2 able to transfer hers from her wheelchair was confused at timfor assistance, but sand she wanted to so sick back in Aprihospitals, and she wantel losing weight. (	d still be alive today."  35 PM, V2, Director of Nursing P) was able to feed herself, but in her room more and and food. (R2) just became have only been the DON here P) was independent and was self without staff assistance in to the bathroom. I know she hes. We would tell her to call she did not always do that, be independent, but she got I. She was going in out of the was declining in her health, R2) was not eating, and not it of her room before she went				

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PRINTED: 08/03/2023 FORM APPROVED

Illinois Department of Public Health

IIIINOIS L	epartment of Public	nealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6001028	B. WING		C 	
		11.6001028	2		07/1	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELM/ /, IL 62035	AR		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 9	S9999			
	"I was going into the week. The facility week. The facility we residents with their resident's weights a would look at what recommendations. not on the sheet, the weight loss. I did not weight loss until 3/1 from four buildings facility we were have had discussed this had then made a country that the weights and the person in charge of I know, they were fis saw (R2's) weight for eweigh her, which following week. I say the diabetes and they to (soda brand) a day, her sugar levels, but review and I was confor her labs to get the understanding of we any labs before 3/2 resident is taking on labs are drawn ever (R2) was sent out to labs were off."  On 7/11/2023 at 9:4 Nurse, (LPN), state a patient here for a and refusing her me	that was going on. I did not see 7/2023. Normally, when a real diabetic medication, our ry 3 months. Then at that time, to the hospital and I know her 43 PM, V22, Licensed Practical d, "I remember (R2). She was long time. She stopped eating redication. Back in April, she spital. I remember sending				

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On 7/11/2023 at 9:09 AM, V2, Director of Nursing,

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		II 000 4000			0	
		IL6001028	D. WINO		07/1	1/2023
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELM/ /, IL 62035	AK		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
\$9999	Orders to be followed was in the facility, and 2023. I am not seed 3/27/2023, and the 7/9/2022 (eight more documents; labs are would expect the factor of condition and or seed of the factor of the Weight Change 9/2022, documents to monitor the nutritic including all signific weight change."  The Change in Respective date of 9/202 of the facility, except alert the resident, represent the resident, represent the resident, represent the physician or nurse potential or	buld expect all Physician ed. I was not here when (R2) s I did not start until April ng any labs done until lab work before that was of this later). I see the POS e to be done every 3 months. I mily be notified of any change weight loss."  e Policy, with a review date of , "It is the policy of this facility ional status of all residents, ant or trending patterns of  ident Condition Policy, with a 22, documents, "It is the policy of in a medical emergency, to esident's physician and ole part of a change in will notify the resident's oractitioner when: There is a creatment or medication. Once een notified and a plan sing or social service staff will and family of the issues and any the the resident and their is well as the physician will be resident's medical record or occuments. The Resident care	S9999			

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Illinois Department of Public Health STATE FORM

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