

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD</b> <b>WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Complaint Investigation: 2441419/IL170033	S 000		
S9999	Final Observations  Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)5)  Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.  Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		

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

Electronically Signed

TITLE

(X6) DATE

02/29/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD</b> <b>WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>review, the facility failed to obtain orders to treat a new pressure ulcer, to prevent deterioration of the pressure ulcer, and failed to have appropriate interventions in place to prevent new pressure ulcers from developing and keep existing pressure ulcers from getting worse for 2 of 4 residents (R3 and R4) reviewed for pressure ulcers in the sample of 11. This failure resulted in R4 developing a Stage 4 Pressure Ulcer on his right buttock.</p> <p>Findings include:</p> <p>1. On 2/22/24 at 9:15 AM V4 (Wound Nurse) provided pressure ulcer treatment to R4's Stage 4 pressure ulcer on his right buttock. V4 stated that the wound was just discovered on 2/20/24. She stated that she has ordered a cushion for his wheelchair (w/c), and he is on an air mattress. She stated R4's pressure ulcer is on the side affected by his stroke, and he cannot feel it and she think this contributed to his not being aware he was getting a sore and not letting anyone know about it. V4 unfastened R4's adult diaper and removed the dressing from the pressure ulcer on his right buttock. The pressure ulcer was larger than a quarter and the wound base was completely covered with yellow slough. There was a moderate amount of drainage noted on the soiled dressing.</p> <p>R4's Face Sheet, undated, documents his diagnoses to include Cerebral Vascular Accident (CVA); Flaccid Hemiplegia Affecting Right Dominant Side; Chronic Obstructive Pulmonary Disease (COPD); Neuropathy; Aphasia; Bipolar Disorder; Schizoaffective Disorder; Major Depressive Disorder; Hypertension (HTN); and Alcohol Dependence in Remission.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>R4's Minimum Data Set (MDS), dated 1/2/24, documented that R4 was severely cognitively impaired, and he uses w/c for mobility and propels self independently. This assessment documented that R4 requires substantial to maximal assist with most Activities of Daily Living (ADLs) including transferring and toileting hygiene and requires supervision with eating and turning and positioning. According to this assessment, R4 is always incontinent of bladder and frequently incontinent of bowel. At the time of this assessment, on 1/2/24, R4 had no unhealed pressure ulcers.</p> <p>R4's Care Plan, dated 6/12/22, documented, "Pressure Ulcer: (R4) has potential for pressure ulcers related to decreased independent mobility. Dx (Diagnosis): CVA w/right hemiplegia, incontinence. Interventions for this Care Plan include doc s/s skin breakdown, Notify MD &amp; family prn of changes in skin status, notify nurse of any new areas of skin breakdown, redness, blisters, bruises or discoloration observed during routine care, Remind/assist as needed to reposition frequently, utilize pressure-reducing mattress, and weekly body assessment."</p> <p>R4's Care Plan, dated 2/15/24, documented, "Skin: At risk for skin complications r/t (related to) open area on right buttocks." This Care Plan was revised on 2/21/24, documented, "Skin: At risk for skin complications r/t wound on right buttock. Interventions for this care plan include: 2-22-24 (brand name protein drink) as ordered, 2-21-24 air mattress as ordered, assist and encourage resident to turn and reposition frequently, educate resident on MD (Medical Doctor) orders for wound care, educate resident on the risks of infection and poor healing r/t non-compliance,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>monitor area for s/s of infection: odor, drainage, color, size, observe and assess regularly, provide skin care after each incontinent episode, RD (Registered Dietician) to assess and recommend, serve diet as ordered, skin check weekly, treatment as ordered, (Wound Physician) to follow."</p> <p>R4's Progress Note, dated 2/14/2024 at 8:47 PM, documented, "Resident has open pressure sore on right buttock. It's roughly 4cm (centimeters) x 3cm. I cleansed it with wound cleaner and put a dressing with TAO (Triple Antibiotic Ointment) on it."</p> <p>R4's progress notes were reviewed for 2/1/24 through 2/14/24 and there was no documentation of R4 having a pressure wound to his right buttock until 2/14/24.</p> <p>R4's Wound Physician Progress Note, dated 2/20/24, incorrectly documented that the Stage 4 Pressure Ulcer as a skin tear and documents and the measurements of his wound as 4cm x 1.5 cm x 0.2 cm.</p> <p>R4's Wound Physician Progress Note, dated 2/22/24, documented, "Non-visit Progress Note: Stage 4 pressure ulcer on Right buttock, not left buttock."</p> <p>R4's Physician Orders, dated 2/22/24, documented, "Silver Sulfadiazine External Cream 1 % (Silver Sulfadiazine). Apply to Left buttock topically every day shift for Stage 4 pressure ulcer Cleanse stage 4 pressure ulcer to left buttock with wound cleanser, apply silver sulfadiazine cream, collagen, calcium alginate, cover with boarder dressing daily until clear". There was no order for a treatment to R4's pressure ulcer before 2/20/24, after R4 was evaluated by V9</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>(Wound Physician) for treatment of R4's facility acquired pressure ulcer that was discovered on 2/14/24, indicating R4's pressure was untreated for 6 days.</p> <p>R4's Braden Scale for Predicting Pressure Sore Risk, dated 1/2/24, documented a score of 13 indicating he is at moderate risk for developing pressure ulcers.</p> <p>On 2/22/24 at 11:20 AM V4 (Wound Nurse) stated that she was not aware of R4's Pressure Ulcer until 2/20/24 which was the first time she observed it, along with V9 (Wound Physician). V4 stated no staff had reported to her that R4 had a pressure ulcer before that. She stated that was the first time she received orders for the treatment of the pressure ulcer. V4 confirmed the pressure ulcer is a stage 4 pressure ulcer on R4's right buttock. V4 stated she had seen the discrepancy in the physician orders and with the wound physician's progress note and stated he had documented the wrong wound location and type of wound on R4's progress note. V4 confirmed the stage 4 pressure ulcer is on R4's right buttock and it is not a skin tear. She stated she had spoken to V9 (Wound Physician), and he is going to send her a revised progress note with the correct information.</p> <p>On 2/22/24 at 11:25 AM V2 (Director of Nursing/DON), stated that any staff who find a pressure ulcer or other skin impairment should notify the physician immediately and have a treatment order in place, and then notify V4 (Wound Nurse), of the new wound so she can follow-up and get the resident on the list to be seen by V9 (Wound Physician). V2 stated that R4 was very resistant to care and often the Certified Nursing Assistants (CNAs) provide incontinent</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD</b> <b>WOOD RIVER, IL 62095</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>care over the toilet because he refuses to lay down, and that might be why they missed the pressure ulcer on his buttock. V2 stated that she does not know why the pressure ulcer was not found on his weekly skin checks before it became a Stage 4.</p> <p>On 2/23/24 at 10:05 AM, V2 stated that there was no documentation of weekly skin being done for R4 prior to the observation of his pressure ulcer on 2/14/24. She stated she does not know when his pressure ulcer started but does not think it would have started a Stage 4 pressure ulcer.</p> <p>On 2/23/24 at 12:33 PM, during phone interview, V13 (Registered Nurse/RN) stated that she received a report on 2/14/24 from a CNA who was putting R4 to bed and providing him with incontinent care that he had an open area on his buttock. V13 stated she went down to assess the wound and put a treatment on it and notified V17 (Nurse Practitioner) via a text message of the new area. V13 stated she did not receive any new orders that evening regarding R4's pressure ulcer. V13 stated that she did not notify the V2 (DON) or V3 (Assistant Director of Nursing/ADON) or V4 (Wound Nurse) of the new pressure ulcer, but did document it in his progress notes. V13 stated she has taken care of R4 again and cannot remember seeing an actual order for a pressure ulcer treatment, but stated she did put some cream on it the other day. V13 stated R4's pressure ulcer looks much worse now than when she first saw it. She stated on 2/14/24 when she first identified the pressure ulcer, it was barely a Stage 1. She stated it was an open wound but didn't look that bad. V13 stated the wound is larger and deeper now and just looks a lot worse. V13 stated she believes the protocol if you find a new pressure ulcer is to document it,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>put a treatment on it and notify the doctor or nurse practitioner. V13 stated she did not notify anyone else of R4's new pressure ulcer.</p> <p>2. On 2/21/24 at 10:05 AM, R3 was lying in her bed on her back. She stated that she was here for rehab because she broke her ankle when she fell at home. R3 stated nobody comes to turn and reposition her in bed. She stated they did turn her one time because she put on her call light and asked them to, otherwise she does not get turned and she knows she needs to or the sore on her bottom will get worse. R3 stated that she worked in the health field for a long time and knows it is important to get pressure off her backside if she wants it to heal, but they just don't have enough staff. R3 stated that she has never told staff she does not want to be turned because she knows how important it is, but they just don't do it and she hates to bother them. She stated they got her out of bed yesterday for therapy but then put her right back in bed because the wound doctor came. R3 stated that yesterday was the first time she got out of bed since she's been here because therapy was delayed with insurance problems.</p> <p>On 2/21/24 at 12:05 PM R3 was laying on her back in her bed. She stated that nobody has turned her.</p> <p>On 2/21/24 at 1:50 PM V4 (Wound Nurse) provided pressure ulcer care for R3. Upon entering R3's room, she was lying on her back. R3 stated they had just cleaned her up because she knew V4 was going to come in and do her treatment. R3 stated she has been on her back all day except for when they turned her and cleaned her up. R3 stated her butt does hurt from lying on her back all day. She stated she has not</p>	S9999		



Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>	
NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>been out of bed since yesterday when therapy got her up for a short time. V4 cleansed the stage 2 pressure ulcer on R3's left buttock. The wound was irregular shaped with dark red base. There was no treatment in place when V4 rolled R3 onto her left side to do the treatment. R3 stated, "They just cleaned me up." V4 applied silver sulfadiazine cream, collagen, and calcium alginate and covered it with a foam dressing. R3 complained that the bed was very uncomfortable to lay on and felt like she had things sticking her in the back and buttocks. V4 stated they would get her an air mattress because she should have one anyway because she has a wound. V4 stated R3 was on a regular mattress right now. V4 stated when the air mattress is put on R3's bed, that will be the pressure relieving device on the bed. V4 stated R3 did not have any type of pressure relieving device on her bed right now and stated R3 should be turned and repositioned every two hours to relieve pressure off her bottom. R3 stated to V4 that she has been on her back all day except during incontinent care. V4 placed a wedge cushion under R3's left hip to relieve pressure and R3 stated that felt a lot better.</p> <p>On 2/21/24 at 2:05 PM, V4 asked V8 (CNA) if R3's pressure ulcer dressing came off during incontinent care and V8 stated that it had come off because R3 had been incontinent of bowel and bladder and the dressing was soiled. V8 stated R3 is not turned and repositioned every two hours because of her fractured ankle and it being so uncomfortable when she is moved for incontinent care. V4 informed her it is still important for R3 to be turned and repositioned every two hours to help her pressure ulcer heal and prevent any other pressure ulcers.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>R3's Face Sheet, printed 2/22/24, documented her diagnoses to include Displaced Bimalleolar Fracture of Right Lower Leg, Asthma, Type 2 Diabetes Mellitus, Other Specified Symptoms and Signs Involving the Circulatory and Respiratory Systems, Non-Displaced Fracture of Neck of Left Talus, Unspecified Fall, Other Reduced Mobility, and Generalized Edema.</p> <p>R3's MDS, dated 2/14/24, documented that she was alert and oriented and she required substantial/maximal assist for turning and repositioning. The assessment further documented that R3 was dependent for all transfers and was incontinent of bowel and bladder. It continued to document that R3 was admitted with one Stage 2 pressure ulcer and has a pressure reducing device for her bed and application of nonsurgical dressings other than to feet. It documents she is not on a turning and repositioning program.</p> <p>R3's Care Plan, initiated 2/18/24 documented, "The focus: Bed Mobility: has a self-care deficit in bed mobility r/t decreased ability to position or reposition self in bed/turn from side to side/ use side rails to move in bed/move from lying to sitting or sitting to lying position. Interventions for this care plan include Position and reposition resident in bed for comfort, joint support, and skin integrity."</p> <p>R3's Care Plan, initiated 2/16/24 documented, "Skin: At risk for skin complication r/t blister right ankle, left gluteus present on admission pressure per wound nurse. Interventions for this care plan include Therapeutic mattress in bed and cushion in chair as appropriate."</p> <p>R3's Skin and Wound Evaluation, dated 2/16/24,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD</b> <b>WOOD RIVER, IL 62095</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>documented that she has a stage 2 pressure ulcer on her left gluteus, middle that was present on admission. Under "Additional Care" this evaluation documented that R3 was to have incontinence management, mattress with a pump, moisture barrier, moisture control, positioning wedge, and turning/repositioning program.</p> <p>R3's Braden Scale for Predicting Pressure Sore Risk, dated 2/9/24, documented a score of 16, indicating she is at risk for developing pressure ulcers.</p> <p>The facility's policy, Pressure Injuries, reviewed 9/2022, documented, "To prevent or reduce the incidence of pressure injuries, standards of practice should be implemented. A pressure injury may be defined as any lesions caused by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are important contributing factors to the development of pressure injuries.</p> <p>The facility's policy, Skin Management: Pressure Injury, reviewed 1/2023, documented, "The following treatment guidelines have been developed to serve as a general protocol for selecting the type of treatment or dressing to be used. However, the facility recognizes that the selection of treatment protocols is individualized based on the resident condition and Health Care Provider practice patterns. Therefore, these are only guidelines and not all-inclusive. An order is required for all treatments. General Guidelines: Implement prevention protocol according to resident needs. Sensory Perception risk factor: watch for nonverbal cues, assess areas of body that do not feel pain for openings or redness. Activity: turn and reposition as needed using a</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BRIA OF WOODRIVER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>393 EDWARDSVILLE ROAD</b> <b>WOOD RIVER, IL 62095</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11  person-centered approach (minimum every 2 hours), reposition in chair, provide appropriate pressure redistribution devices, teach resident to weight shift if appropriate, ensure proper body alignment. Mobility: turn and reposition as needed using a person-centered approach (minimum every 2 hours), provide appropriate pressure reducing devices." It continues, "Under General Treatment Guidelines: 10. The staff nurse will notify the Wound Nurse upon identification of skin impairment. If Wound Nurse is not available, the staff nurse should document the open area on a Skin Screen Form and alert the Health Care Provider for treatment orders. Treatment Guidelines for Stage 2 Pressure Injuries: Turn and reposition as needed using a person-centered approach (minimum of every 2 hours)."  "B"	S9999		