(X6) DATE

Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С	
		IL6001028	B. WING			4/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELM <i>A</i> /, 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 2541728/IL187353				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)1) 300.1210 d)2)					
	a) The facility of procedures governing facility. The written be formulated by a Committee consisting administrator, the amedical advisory confined for an advisory confined facility and othe policies shall complete the facility and shall by this committee, cand dated minutes	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 Persor b) The facility scare and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of					

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

03/13/25 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 10 XEQH11

Illinois Department of Public Health

STATEMEN	ND DLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6001028	B. WING		C 03/04/2025	
NAME OF F	PROVIDER OR SUPPLIER		ORESS CITY S	STATE, ZIP CODE	1 00.0	
			EST DELMA			
BRIA OF	GODFREY	GODFRE	/, 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 APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	and be knowledgear respective resident d) Pursuant to nursing care shall in following and shall I seven-day-a-week I 1) Medical hypodermic, intrave be properly administ 2) All treat be administered as These requirements. Based on observation review, the facility for gastrointestinal feed as ordered for 3 of reviewed for enterafailure resulted in R	care-giving staff shall review ble about his or her residents' care plan. subsection (a), general nclude, at a minimum, the pe practiced on a 24-hour, pasis: tions, including oral, rectal, enous and intramuscular, shall				
	Findings include:					
	with diagnoses of d with loss of conscio	to the facility on 5/29/2024, iffuse traumatic brain injury usness, severe protein-calorie agia, and acute respiratory				
	documented he is s	a Set (MDS), dated 1/1/25, severely cognitively impaired staff to assist with all mobility.				
		ed 5/30/24, documented R2 is ions related to tube feeding				

Illinois Department of Public Health

with a goal to remain free of aspiration

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IIIInois D	epartment of Public	Health				
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		IL6001028	B. WING			, 4/2025
		120001020			03/0	4/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DD14 05	0005051/	1623 29 W	EST DELMA	AR		
BRIA OF	GODFREY	GODFRE	/, IL 62035			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
S9999	Continued From pa	ge 2	S9999			
	pneumonia through	out next review. Interventions				
		e documented to be, in part,				
	administer tube fee					
		•				
	R2's Progress note	s on 2/20/25 at 7:33 PM				
	documented, "(R2)	returned from hospital via				
		ttendants. (R2) is alert per his				
		astrostomy tube) was				
		el sounds) in all 4 quadrants,				
		surgical incision is present to				
		ower abdomen. A drain is				
		ower quadrant. Urinary				
		CTA (lungs clear to				
		na is noted to the RUE (right				
		cluding the hand. Some				
		the buttock. Feedings are 1.5				
	flushes every 4 hou	rs per hour) with 120 mL water				
	ilusties every 4 floo	113.				
	R2's hospital discha	arge orders, dated 2/20/25,				
	•	t tube feedings at 10mL/hr,				
		or q(every) 6hr to goal of				
		onal hospital discharge order				
		polamine 1 mg over 3 days				
		patch on the skin every third				
		ented as last given on 2/17/25				
	at 4:01 PM at hospi					
	•					
		dated 2/20/25 at 6:30 PM,				
		24 hours Enteral Feeding				
	Formula 1.5 Rate 4	5 mL/hr.				
	DOI 14 " "					
	R2's Medication Administration Record					
	documented V7 started administration of R2's					
	Enteral Feeding at	a rate of 45mL/hr at 9:34 PM.				
	D2's Drogress note	dated 2/20/2025 at 0:45 DM				
		, dated 2/20/2025 at 9:45 PM, polamine Transdermal Patch				
		g (milligram) transdermally				
		nausea unavailable."				
	every /2 Hours for I	iausca ui iavaliabic.				

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AND DIAN OF CODDECTION 'IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BOILDING.		C		
		IL6001028	B. WING			4/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELM <i>A</i> /, IL 62035	AR		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	documented, "(R2) feeding coming from having large emesi feeding. (R2) being evaluation. The phoresident's emergen The documenter ur Attorney) via telephoresident's status." R2's Progress note documented, "This (R2) is being admit r/t (related to) food					
	Nurse (LPN), stated returned from the had hand. V7 stated she in his hospital dischanges started R2 at 4 long after he return stated R2 was also his tracheostomy the stated Scopolamine can help with secrewasn't available. V7 doctor for alternative not aspirating while happened after she exactly what happened on 3/4/25 at 9:10 A Assistant (CNA), stated she was not	AM, V7, Licensed Practical d R2 was doing okay when he ospital on 2/20/25, but she swelling to his right arm and e put in R2's orders as written arge paperwork. V7 stated 5mL of tube feeding not too ed back from the hospital. V7 having mucus coming from hat was thick and tan. V7 e patches were ordered and tions and with nausea, but it 7 stated she did not call for the re orders. V7 stated R2 was a she was at the facility, it eleft, and she doesn't know ned. AM, V6, Certified Nursing ated R2 did not verbalize how he was in the facility. V6 sure what happened, but he sues on 2/21/25 before R2				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 2012211101		С	
		IL6001028	B. WING		03/0	4/2025
NAME OF	PROVIDER OR SUPPLIER			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
		ospital, although she did not currance was which made her issues.				
	something coming	AM, V3, CNA, stated R2 had out of his tracheostomy the when he was sent back out to				
	stated R2 could have nausea, and vomition not titrated as record R2's tube feedings too much for him, constated if the Scopol available, an alternative been requested to I vomiting. The patch secretions in patient stated she would respect to the stated s	PM, V8, Nurse Practitioner, we had abdominal distention, ng if his tube feedings were mmended. V8 stated starting at 45mL/hr could have been ausing him to aspirate. V8 amine patches weren't ative medication could have nelp prevent nausea and is also used to help with that with tracheostomies. V8 ecommend keeping a resident at 30-60 minutes after a tube aspiration.				
	diagnoses of femal	ne facility on 1/14/2025, with e intestinal-genital tract resistant staphylococcus nd dysphagia.				
	severely cognitively	/31/25, documented she is rimpaired and dependent on ding and all mobility tasks.				
	at risk for complicate feeding tube. R1 is mechanical soft die pleasure feedings a of bed) raised 30 de	ted 1/15/25, documented R1 is tions related to presence of a allowed to have a regular at and regular liquids for as ordered; keep HOB (head egrees; elevate the head of ees during feeding, check tube				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6001028	B. WING		I	C 04/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
BRIA OF	GODFREY		EST DELMA	AR		
			′, 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 CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
\$9999	placement by auscicheck placement of using auscultation is food/medications/fliresidual as ordered soap and water durby nursing assistan raised 30 degrees; bed 30-45 degrees R1's orders, dated placement of Gtube administering food/orders, dated 1/14/3 stoma site daily with routine care; may be no open areas. R1's continued to documfor signs and symptoskin. On 3/3/25 at 11:03 the nurses will give flat." R1 stated the once in a while." On 3/3/25 at 12:33 with her fruit cup foolike the main dish a available. V3 placed as a substitute, medically as a substitute as a substitute, medically as a substitute as a substitute, medically as a substitute as a substit	ultating air injection every shift; G-tube (gastrointestinal tube) before administering uids, check feeding tube; cleanse stoma site daily with ing routine care; may be done tif no open areas; keep HOB and elevate the head of the during feeding. 1/14/25, documented check ausing auscultation before medications/fluids. R1's 25, also documented cleanse in soap and water during e done by nursing assistant if sorders, dated 1/14/25, tent monitor enteral tube site toms of infection every shift for AM, R1 stated, "Sometimes me tube feedings while I'm staff clean her stoma "every" PM, V3, CNA, assisted R1 r lunch. R1 stated she did not not would like a substitute, if dan order for grilled cheese	S9999			

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•	AND DIAM OF CODDECTION IN IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				c	;
	IL6001028	B. WING		03/0	4/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
BRIA OF GODFREY		EST DELM <i>A</i> , IL 62035	AR		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C 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
stated "oww" every ti applied skin prep to the with split gauze. R1's at 2:35 PM. V4 state the provider to see if new treatment to it. On 3/4/25 at 2:19 PM having same dressing 3/3/25 in place. V9, Lestated she was not to any concerns seen yeard did not look at it require a bolus feeding dressing in place and the skin, despite R1. 3. R3 was admitted the with diagnoses of specified seemalnutrition, and chromal	ine it was touched. V4 the stoma before covering it is tube feeding was completed id she would need to notify if they would like to add any M, R1 was observed as ing from day prior, dated Licensed Practical Nurse, old in report that there were resterday for R1's stoma site, today since R1 did not ing. V9 left the soiled d did not remove it to assess reported it being tender. It to the facility on 9/27/2024, reastic quadriplegic cerebral evere protein-calorie ronic hepatic failure. B/25, documented she is ood, is dependent on ing and requires assistance with rolling left i, sitting to lying on the bed	\$9999			

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R3's active orders, dated 10/23/2024 at 10:00

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	I		/, IL 62035			
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S9999	Continued From pa	ge 7	S9999			
39999	PM, documented, "soap and water durby nursing assistan antibacterial cleans Allow to set for 10 r cotton tip applicator PRN (as needed)." R3's active orders, documented: check auscultation before food/medication/flui On 3/3/25 at 3:31 P room to administer was due at 2:00 PM (DON) was present not gown up while a feeding. V5 did not placement of R3's (her bolus. V2 stated Precautions (EBP) not have a dressing	Cleanse stoma site daily with ing routine care. May be done tif no open areas. Apply er to a 2x2 drain sponge. ninutes or longer. Using a r, apply cream twice daily and dated 10/23/24 at 8:58 PM, a placement of G-tube using administering	39999			
	while they were her during her shift, at s expects a dressing site. V2 stated she	e. V5 is supposed to do that some point. V2 stated she to be in place on R3's stoma expects any staff with direct at on EBP to be gowned and				
		M, V9, LPN, administered a great to R3 without auscultating lent.				
	(R2) was admitted t	M, V1, Administrator, stated, to the hospital with will not be returning to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		С	
		IL6001028	B. WING			4/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BRIA OF	GODFREY		/EST DELM <i>A</i> /, IL 62035	AR		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
S9999	Continued From pa	ge 8	S9999			
	coming out of his tr the morning of 2/21 follow discharge ore absolutely notify a pavailable to see if a be given." V1 stated check for placemer administering anyth checking for residu- stated she expects providing tube feed care as ordered/wrifacility policy.	and, (R2) had tube feeding ach (tracheostomy) and mouth /25. I expect the nurses to ders as recommended, and provider if a prescription isn't in alternative medication cand she expects her nurses to int of G-tubes prior to ling, either by auscultation or al, but always to find a way. V1 staff to be following EBP while ing care and to be providing tten in their charts and per				
	documented the fol placement by aspire the bed should be condered differently, auscultation prior to with soap and water pump, set prescribe the CNA will clean to care; should there is	Feeding Policy, dated 9/2024, lowing guidelines: check tube ation or air insertion, head of elevated 30-45 degrees unless check for placement using a flushing, the site is cleansed or during daily care, turn on ed rate and start feeding, and the tube site during routine be any issues with the site, the nurse who will communicate a provider.				
	dated 10/16/23, doc employs the use of (EBP) to reduce tra (multi-drug resistan and clothing that er glove use during hig activities. Staff utiliz high-contact reside residents require E	ced Barrier Precautions Policy cumented, "Our facility Enhanced Barrier Precautions nsmission of MDROs torganisms) to staff hands inploys targeted gown and gh-contact resident care activities when BP; high contact activities may be or use: central line, urinary be, tracheostomy/ventilator."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		IL6001028	B. WING			C 04/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
BRIA OF	GODFREY		WEST DELMA EY, IL 62035	AR		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 9	S9999			
\$9999	(B)	ige 9	\$9999			

Illinois Department of Public Health

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