STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057505	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF GODFREY	**1623 29 WEST DELMAR , GODFREY, Illinois, 62035**

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation 25411686 / 2681828	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210 d)3)6) 300.3240a) 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 300.1210 General Requirements for Nursing and Personal Care 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. d) Pursuant to subsection (a), general nursing care	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on interview and record review, the Facility failed to ensure a resident with history of falls was assessed appropriately by nursing staff after a fall. This failure would have resulted in a reasonable person enduring pain for over a day due to a rib and clavicle fracture until nursing staff was notified completed an assessment. Findings include: R2's December 2025 Physician Order Sheet (POS) documents a diagnosis of Parkinson's disease with dyskinesia, with fluctuations, chronic respiratory failure, severe protein calorie malnutrition, traumatic subarachnoid hemorrhage without loss of consciousness, abnormal weight loss, delirium due to physiological condition, and anxiety disorder. R2's Minimum Data Set (MDS), dated 8/21/2025, document R2 was severely impaired for cognition for activities of daily living. R2 uses a wheelchair and requires substantial/maximal assistance-Helper does more than half the effort. Helper lifts or holds trunk or limbs	S9999		

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S9999	Continued from page 2 and provides more than half the effort." R2's Care Plan: Falls documents, "(R2) is at risk for falls. Cognitive deficits, Functional Deficits, Poor Balance, Use of Psychotropic Medication. Date Initiated: 11/27/2023." R2's Progress Notes, dated 11/25/2029 at 1:29 PM, Note Text: "CNA'S reported to nurse that resident had a fall yesterday evening 11/24/25, around dinner time, CNA's got resident up without nurses knowledge, ROM (range of motion) and skin assessment provided this shift, resd (resident) does not want staff to touch her arm, Hospice assessed resident with orders to send to ER (emergency room) for eval (evaluation) and tx (treatment)." R2's Progress Notes, dated 11/26/2025 at 2:10PM, "Note Text: Call received from (Hospice Nurse from Hospital) DX (diagnosis of UTI (urinary tract infection) with new ABT (antibiotic orders), Multiple rib fractures and Fractured clavicle. On call Nurse to have PRN (as needed) Morphine for pain control delivery of pain medication to the facility for resident's comfort and pain control." R2's Hospital Report, with an encounter date of 11/25/2205 at 2:39 PM, documents, "I called (Facility) and spoke with nurse. She reported that the patient was found on the floor yesterday around dinner time. She states that somehow, she must have fallen out of her wheelchair. Stated that the medical assistant found her and did not report it to any nursing staff. Nursing staff found out this morning that the patient fell yesterday evening. Nurse stated that the patient had pain to her left shoulder when examined. The patient is nonverbal, bed bound unless in a wheelchair up for food and does not feed herself. Elderly, frail patient observed bed bound in chronic flex/fetal posture, consistent with contractures, Requires full assistance with positioning. The CT scan final results dated 11/25/2025 document, 'the medical portion, right clavicle, the anterior aspect right first, and second ribs are angulated with cortical irregularity could indicate subtle acute fractures. Closed fracture of multiple ribs of right side, initial encounter, closed, nondisplaced fracture of shaft of right clavicle, initial encounter. R2's Initial Report, dated 11/24/2025, documents,	S9999		

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S9999	Continued from page 3 "Resident had fall with injury. Investigation initiated DON (Director of Nursing), POA (Power of Attorney), MD (Medical Doctor) notified. This is our initial report 5 day to follow." R2's Final Report incident date of 11/24/2025 documents, "Resident resides at (Facility) as a long-term care resident. She is alert and oriented x1, she is dependent for mobility throughout the facility as well as a (mechanical lift) transfer. Resident can be impulsive at times; resident sustained a non-witnessed fall in the dining room. After the investigation of the events, the resident was restless in her chair and slid out of her (geriatric) chair. She was sent to the hospital and returned without admission to hospital. Diagnostics show a right clavicle fracture and 1st/2nd ribs with subtle acute fractures and UTI (urinary tract infection) Care plan reviewed and revised to meet resident needs. This is our final report." R2's Progress Notes, dated 11/26/2025 at 12:15 AM, "Note Text: Resident returned to the facility. Resident transported to room, staff assisted residents into the bed and call light placed in reach. Resident seen in ER and treated for Un-witnessed fall, Abnormal CT-Scan, Closed FX (fracture) of multiple ribs on right side, Closed non-displaced Fx of right clavicle, Stercoral colitis, constipation and Acute UTI (urinary tract infection). Resident has new orders for ABT (antibiotics) from ER (emergency room). Discoloration noted to UE (upper extremity). Resident tearful during assessment and PRN (as needed) pain medication given for discomfort." On 12/3/2025 at 6:25 AM, V7, Certified Nursing Assistant (CNA), stated she usually works midnights. R2 fell in the dining room. "I did not witness it but heard she had fallen but she passed away yesterday. If a resident falls, we are supposed to get help and tell the nurse. The nurse will then tell us what to do. I am not sure why (R2) was moved." On 12/4/2025 at 1:29 PM, V8, Certified Nursing Assistant (CNA), stated, "If a resident falls, we are supposed to get help and tell the nurse before moving them because we could make it worse if we moved them and they were injured."	S9999		

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S9999	Continued from page 4 On 12/4/2025 at 4:14 PM, V14, Licensed Practical Nurse (LPN) stated, "If a resident falls, staff are to yell for help and wait for nursing to assess them. If we think there may be an injury, we notify the doctor and send them out. Staff are never to get any resident up without them being assessed first. If they try and get someone up they could easily injure them." On 12/8/2025 at 1:11 PM, V2, Director of Nursing (DON), stated, "I know the previous DON was walked out of the building, but I am not sure what went down. Today, is my first day. If a resident falls, I would expect staff to yell for help, nursing to assess the resident, and if there are any injuries or possible injuries to notify the physician to send them out to the hospital. I would never expect staff to get them up without assessing them and/or notifying nursing and/or are being monitored by staff." On 12/17/2025 at 3:38 PM, V23, Medical Doctor, stated, "If a resident had a fall, I would expect nursing staff to be contacted so they could assess the resident look for possible injury and depending on the nature of the injury that would determine what staff to do next. In this case, (R2) did have a fracture and injury so this is something staff need to know that there was fall." On 12/19/2025 at 12:10 PM, V24, Infection Control Nurse, stated, "I did speak with someone from the hospital. We went back and looked at the cameras, and it was not a medical assistant that found (R2), it was actually a CNA (V25). I am not sure what happened and why no management knew (R2) had fallen until the next day." On 12/19/2025 at 12:10 PM, V25, CNA, stated, "I was in the dining room feeding another person. When I looked over, I saw a (geriatric chair) sitting at the table with no resident. I thought it was odd and when I stood up (R2) was under the table. I was trying to get staff attention and there was an agency nurse there and I thought she saw her under the table." The Facility Fall Prevention and Management Policy, with a revision date of 9/2025, documents," This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the	S9999		

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S9999	Continued from page 5 facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident fallsshall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Evaluate the resident for any injury and notify the physician and emergency contact. Complete a fall incident report in the (Computer) risk management portal." (B)	S9999		