STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145735	A. Building B. Wing	07/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of River Oaks	14500 South Manistee Burnham, IL 60633

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 0686 Level of Harm - 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** 50519 Based on observation, interview, and record review, the facility failed to prevent the development of an avoidable pressure ulcer; failed to timely identify, assess, and treat skin breakdown; failed to provide a plan of care to prevent skin breakdown; failed to provide preventative low air loss mattress; and failed to educate staff on pressure ulcer prevention and treatment. This deficiency applies to 1 resident R77 out of 28 reviewed for pressures in the sample of 28. This failure resulted in R77 sustaining 1 facility-acquired stage 3 sacrum pressure ulcer. Findings include: R77 is [AGE] year-old female admitted to the facility 3/23/23, with diagnoses including but not limited to End Stage Renal Disease, anxiety, and schizoaffective disorder. MDS (Minimum Data Set), dated 3/26/24, showed R77 with no pressure ulcers and at risk for pressure ulcer development, with only a pressure reducing device for chair, but no other pressure ulcer preventative treatments were provided. Care plan, dated 3/24/23, reads, (R77) is at risk for skin complications related to diagnosis of central line associated blood stream infection. Goal: (R77) will maintain adequate skin integrity throughout next review. Interventions: Educate resident on MD (Medical Doctor) orders for wound care. Notify MD of abnormal findings. Registered Dietician to assess and recommend diet. Skin assessment weekly. There were no other care plans developed to prevent R77 from acquiring pressure ulcers. On July 8 at 10:40 AM, R77 stated, I have pain from the wound on my back. I acquired a wound here (pointing to her backside) and turning on my sides helps with the pain. On July 8, 2024, at 10:45 AM observed resident lying on a regular mattress during the interview. R77 indicated the regular mattress has been the only type of mattress she's been on while at the facility. On July 8, at 11:00 AM, surveyor requested wound reports from V5, Wound Nurse. V5, Wound Nurse, indicated all wounds were all on the electronic records. Upon review of the record, R77 showed no wounds that were currently being treated for the resident. On July 8th, surveyor clarified again with V5 if there were any wounds or wound assessments for R77, but did not receive any. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	On July 09,2024 at 1:30PM, V5, Wound Nurse, provided 3 hand-written skin and wound assessments. Surveyor asked when the assessments were completed. V5 indicated she had completed them on July 8, 2024. On record review, no assessment initialed under wound and skin assessments, no treatment noted by the TAR (Treatment Administration Record), for the month of June and July 2024. On July 9, 2024, at 1:40 PM, V18 (Licensed Practical Nurse) said, The treatment orders are under the TAR (Treatment Administration Record). I don't have a binder with the wound treatment in my cart. On July 9, 2024, at 1:55PM, V12 (Licensed Practical Nurse) said, Wound treatments are found under the TAR (Treatment Administration Record), and I don't have a binder in my medication cart with wound treatment. The Wound Nurse has the wound binder. On July 9, 2024, at 1:58PM, V17 (Registered Nurse) said, Wound treatment orders are under the TAR. The Wound Nurse is responsible for the treatment. If dressing gets soiled, I call the wound nurse and she changes the dressing. I don't have a wound treatment binder in my cart. On July 9, 2024, at 2:00PM, V2 (Director of Nursing) said, Wound treatment is under the TAR (Treatment Administration Record). On July 9, 2024, at 2:24 PM, V18 removed a foam dressing for the median back. The wound had no outer layer of skin, with the wound bed skin exposed and with moderate amount of serous drainage, and sacrum wound pressure ulcer observed with loss of skin and damaged tissue with moderate serous drainage. V18 described median back wound as a skin tear with moderate amount of drainage. V18 described the sacrum wound as a stage 2, and was not aware of that wound and treatment for both wounds. V35, Wound Physician assessment reads, sacrum is a stage 3 measuring 2.3x1.3x0.1cm, and median back skin tear measuring 3.7x1.3x0.1cm. On July 11, 2024, at 10:30AM, V2 (Director of Nursing) said, I expect nurses to call physicians for orders when a wound is identified, and notify Power of Attorney. I expect the Wound Nurse to take pictures of the wound and notify the Wound Physician. The Wound Physician will stage the wound and provide orders. The wound rounds are done on Mondays, and pictures are taken and treatment adjusted per resident's needs. The assessments provided by (V5) on July 9, 2024 at 1:30PM was completed by (V5) July 8, 2024, after talking to surveyor and a Tele visit was completed with (V35, Wound Physician) and orders obtained. The wound nurse did not take pictures of the sacrum wound or the back skin tear prior to 7/8/24. On July 11, 2024, at 12:00PM, V35 (Wound Physician) said, I had a tele visit at 6:36PM on July 8, 2024, to see (R77). It was the first time I have seen the sacrum wound, site 1, acquired on 6/4/24, and the back skin tear, site 2, acquired on 7/8/24. I usually classify the wound with the nurse, and I come to the facility every Monday to round and see residents. The facility called me to see (R77) and the Wound Nurse was not aware that (R77) had wound until 7/8/24. I will see (R77) on Monday to make additional recommendations. On July 09, 2024, at 7:36PM, V1, Administrator, presented, Facility Policy Title Skin Management: Pressure Injury Treatment reviewed 04/2024. Which reads: Guidelines: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Implement prevention protocol according to resident needs. Sensory Perception factor: watch for nonverbal cues, assess areas of the body that do not feel pain for an opening redness. Mobility: turn every two hours, reposition in chair every two hours.