STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145655	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Woodriver	393 Edwardsville Road Wood River, IL 62095

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40701 Based on interview and record review, the Facility failed to adhere to their Facility's Abuse Policy and Prevention Program for 1 of 3 residents (R1) in the sample of 3. Findings include: The Facility's Abuse Policy and Prevention Program dated 10/2022 documents, Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. It continues to document, Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. It continues, Informing Local Law Enforcement- The Facility shall also contact local law enforcement authorities in the following situations: When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident. It continues, If there is a reasonable suspicion that a crime has been committed that results in serious bodily harm, a report shall be made to local law enforcement and IDPH (Illinois Department of Public Health) immediately. If there is a reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury, then a report to local law enforcement as soon as possible, but within 24 hours of when the suspicion was formed. (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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Illinois Department of Public Health Incident Report dated 1/11/2025 documents, Incident Category: Drug Diversion. It further documents the victim was R1, who is not capable of communication (due to impaired cognition). It continues to document V4, Licensed Practical Nurse (LPN) and V5, Registered Nurse (RN) as witnesses. The report continues, The Facility notified me (V2) that medications were missing from the cart for resident. The medication in question is Lorazepam. It is scheduled every 6 hours. His last administered dose was 0600 (6 AM) by the midnight nurse. This medication was provided by hospice and was delivered on December 20th. He was provided with 4 (medication) cards for a one month supply. On evenings the night of 1/10 (2025) the third card was zero'd out (marked as empty on the narcotics count book) and 2 doses were given from the new card. Interview with the nurse that worked an evening/night shift recalls that she completed 1 card and started using a new card and that there were 28 (pills) left in the card. The nurse that assumed care of the hall notified the other nurses working on another hall that the medication was not available and they assisted her in reaching out to the hospice team. They learned from hospice the amount and date of last delivery. The three nurses then searched the carts for this missing medication. When they were unable to located this medication they notified me of this issue. Video footage was reviewed and was inconclusive on who took the mediation. (Local) police department was notified and a report was made. Resident was assessed and no negative outcome was noted. The hospice doctor was notified of this occurrence, administrator notified. This report was completed by V2, Director of Nursing (DON). The local police department Incident Report dated 1/15/2025 documents V12, Police Officer responded to the Facility for a report of a theft of medication. It further documents, Complainant called this department to report Lorazepam had been stolen on 1/11/2025. Caller had narrowed down the theft to one nurse and had camera footage of the incident. R1's Progress Notes dated 1/11/2025 documents, Spoke with (V13), RN, with (hospice company) and he stated that the patient should have more accounted for on the Ativan. Stated to the nurse that the DON would like hospice to reorder the Ativan for the resident and bill the facility, RN stated he would order more for the resident, should be out on Monday or Tuesday of next week. On 1/22/2025 at 9:10 AM, V1, Administrator (ADM) stated R1's Ativan was confirmed missing. V1 stated V1 and V2 watched video footage and believe an agency nurse took the medication. V2 stated she expects the nurses to count in between shifts and she did observe V3, Registered Nurse (RN) and the on-coming nurse counting the narcotics at shift change. On 1/22/2025 at 9:53 AM, V2 stated when V4 reached out to the hospice nurse, they determined a card was definitely missing. V2 stated the pharmacy sent 4 cards (Lorazepam, also known as Ativan) on 12/20/2025. V2 stated she attempted to contact V3 to ensure the medication wasn't just misplaced somewhere in the Facility, but received no call back. V2 stated V1 and V2 watched the video footage of V3 on the morning of the incident. V2 stated V3 went all the way down to the end of the hallway, spent 10-20 minutes with the narcotic box left open and kept going in and out of a room of a hospice resident between rummaging in the narcotic box. On 1/22/2025 at 10:15 AM, the video footage was reviewed with V1 and V2 and confirmed what V2 stated in her interview. On 1/22/2025 at 10:35 AM, V7, LPN stated she heard there was a missing medication card, but was unsure if it was ever found. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/2025 at 11:09 AM, V5, RN stated she worked on 1/11/2025, orientation V4. V5 stated a card of medication came up missing when an agency nurse was working that hall (200). V5 stated V3 was the one who discovered it. V5 stated the medication was never located. V5 stated V4 called the pharmacy to see how many cards had been dispensed as well as called hospice to see how much they ordered. V5 stated V4 did the math and saw with what was sent out, he (R1) should have had a whole card left. V5 stated she looked in all the other carts to make sure it wasn't just misplaced and it was never found. On 1/22/2025 at 2:48 PM, V2 stated, By 2:45 (PM-1/11/2025) I was convinced it (R1's Lorazepam) was gone. V2 stated she was not aware of the timeframe regarding notifying law enforcement officials. V2 stated she completed her investigation prior to calling the police so she could have more information to tell them. On 1/22/2025 at 3:04 PM, V1 stated V2 thought V2 had to prove there was a crime committed before calling law enforcement. V1 stated she informed V2 it should be reported immediately, and then proceed with the internal investigation. V1 stated the Facility policy to to report incidents of suspected crime immediately. On 1/27/2025 at 9:45 AM, V1 stated notifying the local police should have been completed more timely.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40701 Based on interview and record review, the Facility failed to inform local law enforcement in a timely fashion related to suspected misappropriation of a narcotic medication for 1 of 3 residents (R1) in the sample of 3. Findings include: The Facility's Illinois Department of Public Health Incident Report dated 1/11/2025 documents, Incident Category: Drug Diversion. It further documents the victim was R1, who is not capable of communication (due to impaired cognition). It continues to document V4, Licensed Practical Nurse (LPN) and V5, Registered Nurse (RN) as witnesses. The report continues, The Facility notified me (V2) that medications were missing from the cart for resident. The medication in question is Lorazepam. It is scheduled every 6 hours. His last administered dose was 0600 (6 AM) by the midnight nurse. This medication was provided by hospice and was delivered on December 20th. He was provided with 4 (medication) cards for a one month supply. On evenings the night of 1/10 (2025) the third card was zero'd out (marked as empty on the narcotics count book) and 2 doses were given from the new card. Interview with the nurse that worked an evening/night shift recalls that she completed 1 card and started using a new card and that there were 28 (pills) left in the card. The nurse that assumed care of the hall notified the other nurses working on another hall that the medication was not available and they assisted her in reaching out to the hospice team. They learned from hospice the amount and date of last delivery. The three nurses then searched the carts for this missing medication. When they were unable to located this medication they notified me of this issue. Video footage was reviewed and was inconclusive on who took the mediation. (Local) police department was notified and a report was made. Resident was assessed and no negative outcome was noted. The hospice doctor was notified of this occurrence, administrator notified. This report was completed by V2, Director of Nursing (DON). The local police department Incident Report dated 1/15/2025 documents V12, Police Officer responded to the Facility for a report of a theft of medication. It further documents, Complainant called this department to report Lorazepam had been stolen on 1/11/2025. Caller had narrowed down the theft to one nurse and had camera footage of the incident. R1's Progress Notes dated 1/11/2025 documents, Spoke with (V13), RN, with (hospice company) and he stated that the patient should have more accounted for on the Ativan. Stated to the nurse that the DON would like hospice to reorder the Ativan for the resident and bill the facility, RN stated he would order more for the resident, should be out on Monday or Tuesday of next week. On 1/22/2025 at 9:10 AM, V1, Administrator (ADM) stated R1's Ativan was confirmed missing. V1 stated V1 and V2 watched video footage and believe an agency nurse took the medication. V2 stated she expects the nurses to count in between shifts and she did observe V3, Registered Nurse (RN) and the on-coming nurse counting the narcotics at shift change. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/2025 at 9:53 AM, V2 stated when V4 reached out to the hospice nurse, they determined a card was definitely missing. V2 stated the pharmacy sent 4 cards (Lorazepam, also known as Ativan) on 12/20/2025. V2 stated she attempted to contact V3 to ensure the medication wasn't just misplaced somewhere in the Facility, but received no call back. V2 stated V1 and V2 watched the video footage of V3 on the morning of the incident. V2 stated V3 went all the way down to the end of the hallway, spent 10-20 minutes with the narcotic box left open and kept going in and out of a room of a hospice resident between rummaging in the narcotic box. On 1/22/2025 at 10:35 AM, V7, LPN stated she heard there was a missing medication card, but was unsure if it was ever found. On 1/22/2025 at 11:09 AM, V5, RN stated she worked on 1/11/2025, orientation V4. V5 stated a card of medication came up missing when an agency nurse was working that hall (200). V5 stated V3 was the one who discovered it. V5 stated the medication was never located. V5 stated V4 called the pharmacy to see how many cards had been dispensed as well as called hospice to see how much they ordered. V5 stated V4 did the math and saw with what was sent out, he (R1) should have had a whole card left. V5 stated she looked in all the other carts to make sure it wasn't just misplaced and it was never found. On 1/22/205 at 12:08 PM, V14, Assistant Director of Nursing (ADON) stated she was told about the 28 Ativan missing the next day. V14 stated she believes an agency nurse took the medication and the card of medication was never found. On 1/22/2025 at 2:48 PM, V2 stated, By 2:45 (PM-1/11/2025) I was convinced it (R1's Lorazepam) was gone. V2 stated she was not aware of the timeframe regarding notifying law enforcement officials. V2 stated she completed her investigation prior to calling the police so she could have more information to tell them. On 1/22/2025 at 3:04 PM, V1 stated V2 thought V2 had to prove there was a crime committed before calling law enforcement. V1 stated she informed V2 it should be reported immediately, and then proceed with the internal investigation. V1 stated the Facility policy to to report incidents of suspected crime immediately. On 1/27/2025 at 9:45 AM, V1 stated notifying the local police should have been completed more timely. The Facility's Abuse Policy and Prevention Program dated 10/2022 documents, Informing Local Law Enforcement- The Facility shall also contact local law enforcement authorities in the following situations: When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a resident. It continues, If there is a reasonable suspicion that a crime has been committed that results in serious bodily harm, a report shall be made to local law enforcement and IDPH (Illinois Department of Public Health) immediately. If there is a reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury, then a report to local law enforcement as soon as possible, but within 24 hours of when the suspicion was formed. It also documents, The purpose of this policy is to assure that the Facility is doing all that is withib it's control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: filing accurate and timely investigative reports.