

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145655	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/03/2025
NAME OF PROVIDER OR SUPPLIER  Bria of Woodriver		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0659</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>(continued on next page)</p>

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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<p>F 0659</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the Facility failed to ensure staff were educated and competent in providing the necessary care and services for tracheostomies for 4 of 4 residents (R2, R4, R5, R6) in the sample of 6. This failure resulted in R2, R4, R5, and R6 being sent out emergently for routine tracheostomy care. R2 was found unresponsive in the Facility and staff performed CPR that was not in accordance with professional standards using R2's primary airway because they did not know how to do so. R2 died in the Facility, and death certificate is pending. This Immediate Jeopardy began on [DATE] at approximately 10:44 PM when R5 was sent to the hospital for suctioning/removal of mucus plug and tracheostomy replacement. V1 and V2 were notified of the Immediate Jeopardy on [DATE] at 9:03 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the removal plan. Findings include: 1-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, respiratory failure, and tracheostomy status. R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, dependent for mobility, and received high concentration oxygen therapy and tracheostomy care. R2's Physician Order dated [DATE] documented R2 had a tracheostomy. R2's Care Plan initiated [DATE] documented R2 was at risk for breathing difficulty and complications related to tracheostomy placement. R2's Progress Note dated [DATE] at 8:20 AM documents R2 had two episodes of brown tube feeding colored fluid projecting from trach in a large amount. EMS was called for transport to hospital, and there was no documentation that R2's tracheostomy was suctioned. R2's emergency room (ER) Note dated [DATE] documents R2 came from Facility with tube feeding coming out of tracheostomy. R2 had no distress in the hospital and had been seen there frequently for the same issue. R2's Progress Note dated [DATE] at 1:00 PM documents R2 had increased secretions that changed from clear to brownish in a large amount. EMS was called for transport to hospital, and there was no documentation that R2's tracheostomy was suctioned. R2's ER Note dated [DATE] documents R2's tracheostomy tube was suctioned, cleaned, and monitored without any additional increased secretions. The cause of R2's symptoms was unclear with a plan to send him back to the nursing home. R2's Progress Note by V9, Licensed Practical Nurse (LPN), dated [DATE] at 6:00 PM documents, Aides were in room giving patient care when they grabbed nurse and alerted her that resident was unresponsive at 4:50pm, CPR started for 1q0 (10) minutes before EMS (Emergency Medical Technicians) arrived and took over. EMT performed CPR until 5:30pm when they called time of {sic} death. On [DATE] at 12:43 PM, V8, CNA, stated she helped perform CPR on R2 on [DATE]. V10, Registered Nurse (RN), started compressions while she placed the respiratory bag over R2's mouth because she was not aware it needed to be on the tracheostomy. She stated, I don't even know how to attach the thing. I have never bagged a trach before. I think that is something we need to be educated on. None of us in there knew. I even asked. (V10) gave me the oxygen and I just took the bag and went with the mouth because that's all I knew how to do. (V10) said she did not know how to attach it either. On [DATE] at 2:55 PM, V10 stated there was tube feeding coming out of R2's tracheostomy during CPR, so they just placed the respiratory bag over his face and turned the oxygen up. The (Local Fire Department) Incident Report dated [DATE] at 5:15 PM documents Fire Department arrived while staff were performing CPR on R2. Staff stated they were bagging the patient's mouth and not his tracheostomy tube due to secretions coming from the tube while CPR was being performed. On [DATE] at 2:37 PM, V22, (Local) Fire Department Chief, stated when his staff arrived to the facility on [DATE], Facility staff were bagging R2 with the BVM (Bag Valve Mask) over the naso-oral pharynx which is not the standard place for the BVM when the resident has a tracheostomy. The BVM should have been via tracheostomy. V22 stated over the past several months, the Fire Department has encountered multiple issues with tracheostomy residents at the Facility, making him question the care they receive, as far as keeping airways clear and patent so the residents can breathe. He stated they get calls for shortness of breath on a tracheostomy resident, and it is often something as simple as suctioning or cleaning of the tracheostomy tube or applicator. He stated these should be part of routine maintenance that he would expect from a facility that allows tracheostomies to be there. On [DATE] at 8:12 AM, V3, Local Fire Department Paramedic, stated R2 was sent to the hospital frequently for tracheostomy secretions and does not think the Facility has the staff they need to care for the residents with tracheostomies. On [DATE] at 9:30 AM V4</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the Facility failed to provide Cardiopulmonary Resuscitation (CPR) according to accepted professional standards for 2 of 2 residents (R2, R1) reviewed for CPR in the sample of 6. This failure resulted in R1 and R2 not receiving adequate respiratory ventilation when staff did not provide rescue breathing via R1 and R2's primary airway of tracheostomy. R1 and R2 both died while in the Facility, and death certificates are pending. This Immediate Jeopardy began on [DATE] at 6:40 PM when R1 was found unresponsive, and CPR was not performed in accordance with professional standards. V1 and V2 were notified of the Immediate Jeopardy on [DATE] at 11:37 AM. The surveyor confirmed through observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate implementation and effectiveness of the removal plan. Findings include: 1-R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, asthma, and tracheostomy status. R1's MDS dated [DATE] documented R1 was cognitively intact and independent with mobility. R1's Physician Orders do not document supplemental oxygen orders. R1's Care Plan initiated [DATE] documented R1 was a full code. R1's Progress Note by V34, Registered Nurse (RN), on [DATE] at 10:27 PM documents V11, Certified Nursing Assistant, informed V34 that the R1 appeared blue and to come assess him. Staff initiated CPR and continued until Emergency Medical Services (EMS) arrived. EMS continued resuscitation efforts until (Local Hospital) cleared them to call time of death at 7:14 PM. On [DATE] at 1:15 PM, V34 stated we tried to do CPR for R1 over his tracheostomy, but we did not have the correct tubing to attach it, so we just tried to cover the tracheostomy with a gloved hand and attempted bagging (placing Bag Valve Mask, BVM) over his mouth. On [DATE] at 1:45 PM, V11 stated staff did not provide any ventilation for R1 during CPR and only did chest compressions. There were multiple (BVM) bags in the room, but none would fit over his tracheostomy. The one on the crash cart did not work either, so they continued with compressions, but did not provide any ventilation during the resuscitation. 2-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, paraplegia, respiratory failure, and tracheostomy status. R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, dependent for mobility, and received high concentration oxygen therapy and tracheostomy care. R2's Physician Order dated [DATE] documented R2 was a full code. R2's Care Plan initiated [DATE] documents R2 is a full code and wishes will be honored. R2's Progress Note by V9, Licensed Practical Nurse (LPN), dated [DATE] at 6:00 PM documents, Aides were in room giving patient care when they grabbed nurse and alerted her that resident was unresponsive at 4:50pm, CPR started for 1q0 (10) minutes before EMTS (Emergency Medical Technicians) arrived and took over. EMT performed CPR until 5:30pm when they called time of death. On [DATE] at 1:55 PM, V9 stated there were two CNAs whose names she was unable to recall in R2's room caring for him. V9 was standing outside in the hallway with the medication cart waiting for them to finish care so she could go in and give R2 his medications. V9 left for a break at 4:43 PM, and the CNAs let her know at that time R2 would probably need suctioning when they were finished. When V9 returned from break, EMS was in the Facility and had already stopped resuscitation efforts. On [DATE] at 12:43 PM, V8, CNA, stated she was working on another unit when a code was called on the 200 Hall. She ran to R2's room and could tell he was not breathing. V10, Registered Nurse (RN) started compressions, and V8 started bagging R2 by mouth. She was not aware the bag had to be on the tracheostomy and stated, I don't even know how to attach the thing. I have never bagged a trach before. I think that is something we need to be educated on. None of us in there knew. I even asked. (V10) gave me the oxygen and I just took the bag and went with the mouth because that's all I knew how to do. (V10) said she did not know how to attach it either. On [DATE] at 2:55 PM, V10 stated on [DATE] around 4:50 PM, a CNA whose name she cannot remember came and told her R2 was unresponsive. R2's nurse was on break at that time. R2 was a full code, and CPR was initiated. There was tube feeding coming out of R2's trach, so they just placed the respiratory bag over his face and turned the oxygen up. The (Local Fire Department) Incident Report dated [DATE] at 5:15 PM documents, FD (Fire Department) units arrived on scene and found staff bagging the patients mouth and performing CPR on the patient while he was still in bed. Staff states they were bagging the patients mouth and not his trach tube due to secretions coming from the tube while CPR was being performed. FD crew marked the patient was cold to the touch while attempting to find a femoral pulse, no</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the Facility failed to ensure changes in condition were reported for timely assessment and intervention for 1 of 3 residents (R2) reviewed for change in condition in the sample of 6. This failure resulted in R2 showing a change in condition with dilated pupils, hand to touch cool body temperature and decreased baseline response to care on [DATE] when V11 and V12 were providing care to R2. V11 and V12 stated they did not inform R2's nurse of R2's changes. Approximately 15-20 minutes later, V12 returned to check on R2 and R2 was found unresponsive and Cardiopulmonary Resuscitation (CPR) was initiated. R2 died in the Facility, and death certificate is pending. This Immediate Jeopardy began on [DATE] at approximately 5:00 PM when R2 displayed changes from his baseline that were not reported to his nurse. V1 and V2 were notified of the Immediate Jeopardy on [DATE] at 2:12 PM. The surveyor confirmed by interview, observation, and record review Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the removal plan. Findings include: 1-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, paraplegia, respiratory failure, and tracheostomy status. R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, dependent for mobility, and received high concentration oxygen therapy and tracheostomy care. R2's Physician Order dated [DATE] documented R2 was a full code. On [DATE] at 1:45 PM, V11, Certified Nursing Assistant (CNA), stated she was helping another aide clean R2 on [DATE]. She noticed R2's skin was cool, and he seemed more relaxed than normal. She said usually R2's eyes are wide open and moving from side to side, but this day they were more droopy and he just seemed calmer than normal. V11 did not tell the nurse about these changes and went on to help another resident. On [DATE] at 3:13 PM, V12 (CNA) stated, 'I've done nursing homes for 30 years. I could tell by (R2)'s eyes that his pupils had dilated a little bit. Around 5:00 PM another young lady helped me clean him up. I said, 'His pupils are dilated a little.' He was still breathing and everything. We cleaned him up. I couldn't wash his arm because it was really stiff. Usually (R2) tries to bat us away with his little arm that is all curled up, but he was stiff, and we had to lift his arm to wash his armpit. V12 said she did not convey these changes to the nurse and went on to care for another resident. V12 checked back on R2 15-20 minutes later and he was not responding. She told the nurse she thought R2 expired and she needed to go check on him. She said the nurse was moving too slow and it took her one or two minutes to get down to R2's room. When the nurse got there, CPR was initiated. On [DATE] at 1:55 PM, V9, Licensed Practical Nurse (LPN), stated there were two CNAs whose names she cannot remember caring for R2 right before he was found unresponsive. V9 was right outside R2's room with the medication cart waiting them to finish with R2 so she could give him his medications. These CNAs did not tell her R2 had any changes from his baseline, so V9 left for a break. When she returned from break, EMS (Emergency Medical Services) was in the building and had already called R2's death. On [DATE] at 2:55 PM, V10, Registered Nurse (RN), stated a CNA whose name she cannot remember told her R2 was unresponsive. R2's nurse was on break at that time. CPR was performed for 15-20 minutes, then EMS arrived and took over. V10 was checking vital signs and was never able to get anything, like he was already gone. The (Local) Fire Department Incident dated [DATE] at 5:15 PM documents Fire Department arrived on scene while staff was performing CPR on R2. Fire Department Crew attempted to find a femoral pulse and noted R2 was cold to the touch. On [DATE] at 9:30 AM, V4, Local Fire Department Paramedic, stated staff were performing CPR on R2 when they arrived at the Facility. R2 had no femoral pulse and was cold to the touch, so he questioned when R2 was last known to be well. On [DATE] at 11:00 AM, V8, CNA, stated R2 was already starting to stiffen up during CPR. On [DATE] at 1:48 PM, V19, CNA, stated R2 was already cold when CPR was being performed. On [DATE] at 2:09 PM, V20, CNA, stated she helped perform CPR on R2 and he was already cold. On [DATE] at 3:50 PM, V33, Medical Director, stated he would expect staff to report any changes in condition to the nurse on duty. On [DATE] at 1:40 PM, V2, Director of Nursing (DON) stated if a resident experiences a change in condition, staff should report it to the nurse. If the resident's nurse is not available, they should report it to another nurse that is available. R2's change of condition was not reported to her, and she had no idea why they would not have reported those changes to the nurse on duty. The Facility's Change In Resident Condition Policy reviewed 10/2024 documents, It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. The policy does not</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, observation, and record review, the Facility failed to ensure nursing staff had the knowledge, skills, and necessary supplies to provide tracheostomy care for 5 of 5 residents (R1, R2, R4, R5, R6) reviewed for respiratory care in the sample of 6. This failure resulted in Cardiopulmonary Resuscitation (CPR) not being performed in accordance with professional standards on R1 and R2 and caused unnecessary emergency hospital transport for R4, R5 and R6. R1 and R2 died in the Facility, and death certificates are pending. This Immediate Jeopardy began on [DATE] at 10:44 PM when staff were unable to replace R5's tracheostomy and adequately suction R5 to ensure airway remains clear and patent. V1 and V2 were notified of the Immediate Jeopardy on [DATE] at 9:03 AM. The surveyor confirmed by record review, interview and observation that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the removal plan. Findings include: 1-R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), asthma, and tracheostomy status. R1's MDS dated [DATE] documented R1 was cognitively intact and independent with mobility. R1's Care Plan initiated [DATE] documented R1 was a full code and was at risk for shortness of breath related to COPD, acute respiratory failure, and tracheostomy. R1's Progress Note by V34, Registered Nurse (RN), documents, (V11, CNA) informed this nurse that the resident appeared blue and to come assess. On [DATE] at 1:15 PM, V34 stated staff tried to provide ventilation for R1 over his tracheostomy, but did not have the correct tubing to attach the respiratory bag, so we just tried to cover the tracheostomy with a gloved hand and attempted bagging over his mouth. On [DATE] at 1:45 PM, V11, Certified Nursing Assistant (CNA), stated staff did not provide ventilation for R1 during CPR and only performed chest compressions. There were multiple respiratory bags in the room, but none would fit over his tracheostomy. The bag on the crash cart did not work either, so they continued with compressions and did not provide any ventilatory support. 2-R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage, respiratory failure, and tracheostomy status. R2's Minimum Data Set (MDS) dated [DATE] documented R2 was severely cognitively impaired, dependent for mobility, and received high concentration oxygen therapy and tracheostomy care. R2's Physician Order dated [DATE] documented R2 had a tracheostomy. R2's Care Plan documented R2 was a full code and was at risk for complications related to tracheostomy placement. R2's Progress Note dated [DATE] at 8:20 AM documents R2 had two episodes of brown tube feeding colored fluid projecting from trach in a large amount. There was no documentation that R2 was suctioned, and EMS was called for transport to hospital. R2's emergency room (ER) Note dated [DATE] documents R2 came from Facility with tube feeding coming out of tracheostomy. R2 had no distress in the hospital and has been seen frequently for the same thing. R2's Progress Note dated [DATE] at 1:00 PM documents R2 had increased secretions that changed from clear to brownish and in large amount. There was no documentation that R2 was suctioned in the Facility, and R2 was transferred by EMS to the hospital. R2's ER Note dated [DATE] documents R2's trach tube was suctioned, cleaned, and monitored without any additional increased secretions. The cause of R2's symptoms was unclear and R2 would be sent back to the nursing facility. R2's Progress Note by V9, Licensed Practical Nurse (LPN), dated [DATE] at 6:00 PM documents, Aides were in room giving patient care when they grabbed nurse and alerted her that resident was unresponsive at 4:50pm, CPR started for 1q0 (10) minutes before EMTS (Emergency Medical Technicians) arrived and took over. EMT performed CPR until 5:30pm when they called time of (sic) death. On [DATE] at 12:43 PM, V8, CNA, stated she helped perform CPR on R2 on [DATE]. V10 started compressions, and she placed the respiratory bag over R2's mouth because she was not aware it had to be on the tracheostomy. She stated, I don't even know how to attach the thing. I have never bagged a trach before. I think that is something we need to be educated on. None of us in there knew. I even asked. (V10) gave me the oxygen and I just took the bag and went with the mouth because that's all I knew how to do. (V10) said she did not know how to attach it either. On [DATE] at 2:55 PM, V10, Registered Nurse (RN), stated when CPR was performed on R2 on [DATE], there was tube feeding coming out of R2's tracheostomy, so they just placed the respiratory bag over his face and turned the oxygen up. The (Local) Fire Department Incident dated [DATE] at 5:15 PM documents Fire Department arrived while staff were performing CPR. Staff stated they were bagging the patients mouth and not his tracheostomy tube due to secretions coming from the tube while CPR was being</p>		