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	11/20/2025

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 0659 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to ensure staff were knowledgeable and competent to provide emergent tracheostomy reinsertion for 1 of 1 resident (R2) in the sample of 1. This failure resulted in R2 being transported via EMS (Emergency Medical Services) for reinsertion of a trach after dislodgement after nursing staff on duty failed to attempt to reinsert the trach because they weren't properly trained and didn't feel comfortable/confident in doing so. R2 remains in the Intensive Care Unit following trach reinsertion. This has the potential to affect current and new admissions that require tracheostomy care. This resulted in an Immediate Jeopardy which began on 11/2/2025 at approximately 2:30 AM when R2 was sent to the hospital for reinsertion of trach replacement. On 11/14/2025 at 11:00 AM V2, Director of Nurses/Administrator in Training (AIT) and V3, Assistant Director of Nurses (ADON) were notified of the Immediate Jeopardy. The surveyor confirmed by interview and record review the Immediate Jeopardy was removed on 11/18/2025 at 3:05 PM but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include:R2's Undated Face Sheet, documents he was initially admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), trach, gastrostomy (G-Tube), supraventricular tachycardia (SVT), anemia, atrial fibrillation (A-Fib), pneumonia, sepsis, weakness, bilateral paralysis of vocal cords and larynx, hypoxemia, left ventricular failure, aneurysm of the ascending aorta without rupture, saddle embolus of pulmonary artery and congestive heart failure.R2's NRSG (Nursing) admission Assessment, dated 10/30/2025 documents reason for admission: rehabilitation. Other related illnesses and/or previous hospitalizations: acute respiratory failure, saddle PE, pneumonia, hypertension, high cholesterol, VT, A-Fib. Respiratory: regular unlabored, oxygen humification at 28%. Lung sounds: clear and diminished, resident has a trach which is size 6. The Facility's Staffing Pattern dated 11/1/2025 documents 2 agency LPNs (Licensed Practical Nurses) on night shift.R2's Late Entry Nurse's Note, dated 11/2/2025 at 2:30 AM V18, Licensed Practical Nurse (LPN) documents the resident's trach was out. No RN (Registered Nurse) was on duty, so resident was sent out to the emergency room. Resident was (sic) vital was monitored until EMS (Emergency Medical Services) arrived. On call staffing was also notified. No documentation staff attempted to reinsert R2's trach or what his vital signs including oxygen saturation was at that time. On 11/12/2025 at 1:25 PM V18, LPN stated she was an agency nurse. V18 stated V11, CNA (Certified Nurse's Assistant) reported to her that R2 fell out of bed at approximately 2:30 AM and his trach was out. V18 stated she assessed R2's head had a laceration at that time, and she used nursing judgement and called EMS to transport R2 to the local emergency room (ER.) V18 stated she didn't attempt to reinsert R2's trach at that time because she wasn't in-serviced on how to do that and she didn't feel comfortable or confident in attempting to reinsert a trach. V18 stated it was night shift and there was no RN in the building, and she felt R2 needed to be assessed by a physician. V18 stated there was only one other LPN working and she asked her if she knew how to reinsert a trach and she told her it isn't in the LPN nurse's scope of practice to reinsert trachs. V18 stated she didn't know what size R2's trach was or that trachs come in different sizes and she didn't know where to find that (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0659 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	information. V18 stated she didn't know if there was a back up trach emergency kit in R2's room and didn't know where to locate a backup trach or supplies either. On 11/12/2025 at 3:50 PM V19, LPN stated she was an agency nurse and worked night shift on 11/1/2025 into 11/2/2025. V19 stated after V18 called EMS and R2 was transferred to the ER V18 asked her if she should have reinserted R2's trach and V19 told her that that's not in the LPN nurse's scope of practice and so she shouldn't do it. V19 stated at no time did V18 ask her to assist her to take care or assess R2 and she wouldn't have attempted to reinsert R2's trach after it was dislodged because she wasn't in-serviced on trach reinsertion prior to working at the facility and she didn't feel comfortable or confident in even attempting to reinsert a trach. V19 stated there were 2 nurses working the night shift and no RNs were in the building. V19 stated she's never been assigned to a resident with a trach so she doesn't know where the trach size is documented, or where or what supplies are needed to care for a trach.R2's Hospital Emergency Department (ED) Paperwork, dated 11/2/2025 documents principle problem: acute respiratory failure with hypoxia and hypercapnia. Pt (patient) presents to the ED via EMS. Patient is supposed to have a trach in place that is not present. Physical exam: trach site with no patency, unable to replace trach, decreased breath sounds bilaterally with shallow respirations, tachypneic. Clinical notes: will attempt to replace trach and evaluate for airway compromise. Diagnosis: trach complication. Disposition: transfer to larger hospital. General comments: Patient had trach placed for vocal cord paralysis. We were unable to replace trach here. Patient discussed with a larger hospital ENT (Ear, Nose Throat) and they will replace trach there. On 11/14/2025 at 8:56 AM V2, DON/AIT stated all nurses including agency nurses were in-serviced on emergency trach reinsertion in October 2025 and then again in November 2025. V2 stated to her knowledge all nurses, including agency nurses have been in-serviced on emergency trach reinsertion prior to working at the facility and no agency nurses have voiced that they don't feel confident or comfortable with reinserting a trach in an emergent situation. V2 stated when a resident's trach is dislodged for any reason she expects the nurse to reinsert the trach and document the trach reinsertion attempts in the resident's medical record and if the nurse is unsuccessful in trach reinsertion she expects the nurse to call for EMS to assist and if they can't reinsert the trach and stabilize the resident she expects EMS to transport the resident to the emergency room. V2 stated when a trach is dislodged the resident airway is compromised and the resident could experience respiratory distress and could cause respiratory failure and could lead to death. V2 stated she didn't know if reinserting a trach is within an LPNs scope of practice and that she'd have to look that up.On 11/14/2025 at 12:25 PM V3, ADON stated the facility's trach care policy doesn't document instructions on how to reinsert a trach if it is dislodged and they have been in-servicing nurses using a trach care skills checklist this week, but it also didn't include trach insertion instructions. V3 clarified the facility doesn't have a policy or skill checklist that covers trach reinsertion, so no staff have been in-serviced on trach reinsertion. V3 stated the facility is currently working on finding a trach skills checklist for trach reinsertion so they can in-service nurses on it. On 11/13/2025 at 11:05 AM V20, Nurse Practitioner (NP) stated she expected nurses including agency nurses to be in-serviced/educated on emergent trach care including trach reinsertion because when a resident has a trach it is considered medically necessary for breathing and when a trach is dislodged for any reason it should be reinserted immediately because without it could lead the resident to having respiratory distress which could lead to brain death. V20 stated an emergency trach reinsert kit should be in his room, and she expected there to be one in R2's room in case of dislodgement. V20 stated she expected staff to document resident's trach size in the resident's medical record so nurses would know what size to reinsert if the trach is dislodged.The Facility's Tracheostomy Care Policy revised 10/2024 documents, it is the policy of this facility that residents with tracheostomies receive routine care to maintain a patent airway. No documentation regarding trach reinsertion is addressed in the facility policy. The Facility's Facility Assessment dated 6/18/2025 documents the Facility provides care for COPD, pneumonia, asthma, chronic lung disease, and respiratory failure. Specialized Rehabilitation Services include Respiratory. Special Care (continued on next page)

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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 0659 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Needs include tracheostomy care and ventilator care.The facility took the following actions to remove the immediacy and prevent any additional residents from suffering an adverse outcome. Completion dated: 11/14/2025. R2 no longer resides at the facility. All new trach patients have the potential to be affected by alleged deficient practice. All nurses will be in-serviced by the DON/Designee on emergent and routine trach care initiated on 11/14/2025 & completed on 11/14/2025. Nurses will be in-serviced prior to the start of their next shift. Agency nurses will be in-serviced prior to the start of their next shift by the DON/Designee on emergent and routine trach care initiated on 11/14/2025 & completed on 11/14/2025. Nurses will be in-serviced prior to the start of their next shift.Actions to Prevent Occurrence/Recurrence: the facility took the following actions to prevent an adverse outcome from reoccurring. Trach in-servicing - completed once a month for 3 months starting 11/14/2025 by the DON/Designee. Audit logs: - 3 nurses will be observed on trach competency weekly for 4 weeks by DON/Designee initiated 11/14/2025. QAPI Review: Committee will access outcomes and adjust training as needed weekly during QA and initiate 11/14/2025.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary emergent care and services for 1 of 1 resident (R2) with a tracheostomy in the sample of 1. This failure resulted in R2 being sent out urgently via EMS (Emergency Medical Services) for trach reinsertion after staff failed to attempt to reinsert R2's trach when it was found dislodged. R2 was admitted to the ICU (Intensive Care Unit) for respiratory distress. This has the potential to affect current and new admissions that require tracheostomy care.This Immediate Jeopardy began on 11/2/2025 at approximately 2:30 AM when R2 was sent to the hospital for reinsertion of trach replacement. On 11/14/2025 at 11:00 AM V2, Director of Nurses (DON)/Administrator in Training (AIT) and V3, Assistant Director of Nurses (ADON) were notified of the Immediate Jeopardy. The surveyor confirmed by interview and record review the Immediate Jeopardy was removed on 11/18/2025 at 3:05 PM but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R2's Undated Face Sheet, documents he was initially admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), trach, gastrostomy (G-Tube), supraventricular tachycardia (SVT), anemia, atrial fibrillation (A-Fib), pneumonia, sepsis, weakness, bilateral paralysis of vocal cords and larynx, hypoxemia, left ventricular failure, aneurysm of the ascending aorta without rupture, saddle embolus of pulmonary artery and congestive heart failure.R2's NRSG (Nursing) admission Assessment, dated 10/30/2025 documents reason for admission: rehabilitation. Other related illnesses and/or previous hospitalizations: acute respiratory failure, saddle PE, pneumonia, hypertension, high cholesterol, VT, A-Fib. Respiratory: regular unlabored, Oxygen humification at 28%. Lung sounds: clear and diminished, resident has a trach which is size 6. R2's Late Entry Nurse's Note, dated 11/2/2025 at 2:30 AM V18, LPN (Licensed Practical Nurse) documents an unwitnessed fall for R2. R2 was found lying on the floor on the right side of his bed within reach of call light. R2 stated he was trying to get up. R2 was immediately assessed by this nurse. R2 was alert and oriented 2-3, denied any loss of consciousness but confirm his head hit the floor, vital was (sic) stable. Upon getting R2 back in bed, I noticed a small laceration to the right side of the forehead above the eyebrow and that trach was out. R2 complained of no pain or trouble breathing. No RN (Registered Nurse) was on duty, so R2 was sent out to the emergency room. R2 was vital was monitored until EMS (Emergency Medical Services) arrived. On call staffing was also notified. No documentation staff attempted to reinsert R2's trach or what his vital signs including oxygen saturation was at that time. On 11/12/2025 at 1:25 PM V18, LPN stated she was an agency nurse and was assigned to R2 on night shift on 11/1/2025 into 1/2/2025. V18 stated she got to the facility around 10:00 PM and did rounds at that time. V18 stated R2 was lying in bed and was resting. V18 stated R2 had a trach and it was in and connected to oxygen when she did the initial rounds that shift. V18 stated V11, CNA (Certified Nurse Assistant) reported to her that R2 fell out of bed at approximately 2:30 AM and she went and assessed him immediately. V18 stated during the assessment of R2 he was lying on the right side of his bed on the floor and his trach was out. V18 stated she assessed R2's head had a laceration at that time, and she used nursing judgement and called EMS to transport R2 to the local emergency room (ER.) V18 stated she assessed R2's oxygen and while he laid on the floor and it was low 90's and then staff transferred R2 back to bed and she placed oxygen via an oxygen mask, and his oxygen went to 95%-96%. V18 stated R2 didn't experience respiratory distress and EMS transported him to the ER. V18 stated she didn't attempt to reinsert R2's trach at that time because she wasn't in-serviced on how to do that and she didn't feel comfortable or confident in attempting to reinsert a trach. V18 stated it was night shift and there was no RN in the building, and she felt R2 needed to be assessed by a physician. V18 stated there was only one other LPN working and she asked her if she knew how to reinsert a trach and she told her it isn't in the LPN nurse's scope of practice to reinsert trachs. V18 stated she didn't know what size (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	R2's trach was or that trachs come in different sizes and she didn't know where to find that information. V18 stated she didn't know if there was a back up trach emergency kit in R2's room and didn't know where to locate a backup trach either. On 11/12/2025 at 3:50 PM V19, LPN stated she was an agency nurse and worked night shift on 11/1/2025 into 11/2/2025. V19 stated she wasn't assigned to R2 and she didn't assist or assess R2 at anytime that shift. V19 stated after V18 called EMS and R2 was transferred to the ER V18 asked her if she should have reinserted R2's trach and V19 told her that that's not in the LPN nurse's scope of practice and so she shouldn't do it. V19 stated at no time did V18 ask her to assist her to take care or assess R2 and she wouldn't have attempted to reinsert R2's trach after it was dislodged because she wasn't in-serviced on trach reinsertion prior to working at the facility and she didn't feel comfortable or confident in even attempting to reinsert a trach. V19 stated she's never been assigned to a resident with a trach, so she doesn't know where the trach size is documented, or what supplies are needed to care for a trach.On 11/6/2025 at 10:45 AM V15, stated she is R2's POA (Power of Attorney) stated R2's trach fell out when he fell out of bed in the middle of the night on 11/2/2025 and he was transferred to the local emergency room. That hospital told her they didn't have proper staff to reinsert the trach so he had to be transferred to a larger hospital out of state. That hospital reinserted his trach and he was admitted to the intensive care unit (ICU) for respiratory distress and he is still in the ICU.R2's Hospital Emergency Department (ED) Paperwork, dated 11/2/2025 documents principle problem: acute respiratory failure with hypoxia and hypercapnia. Pt (patient) presents to the ED via EMS. Patient is supposed to have a trach in place that is not present. Physical exam: trach site with no patency, unable to replace trach, decreased breath sounds bilaterally with shallow respirations, tachypneic. Clinical notes: will attempt to replace trach and evaluate for airway compromise. Diagnosis: trach complication. Disposition: transfer to larger hospital. General comments: Patient had trach placed for vocal cord paralysis. We were unable to replace trach here. Patient discussed with a larger hospital ENT (Ear, Nose Throat Specialist) and they will replace trach there. On 11/14/2025 at 8:56 AM V2, DON/AIT stated all nurses including agency nurses were in-serviced on emergency trach reinsertion in October 2025 and then again in November 2025. V2 stated to her knowledge all nurses, including agency nurses have been in-serviced on emergency trach reinsertion prior to working at the facility and no agency nurses have voiced that they don't feel confident or comfortable with reinserting a trach in an emergent situation. V2 stated when a resident's trach is dislodged for any reason she expects the nurse to reinsert the trach and document the trach reinsertion attempts in the resident's medical record and if the nurse is unsuccessful in trach reinsertion she expects the nurse to call for EMS to assist and if they can't reinsert the trach and stabilize the resident she expects EMS to transport the resident to the emergency room. V2 stated when a trach is dislodged the resident airway is compromised and the resident could experience respiratory distress and could cause respiratory failure and could lead to death. V2 stated she didn't know if reinserting a trach is within an LPNs scope of practice and that she'd have to look that up. On 11/13/2025 at 11:05 AM V20, Nurse Practitioner (NP) stated she assessed R2 on 10/31/2025. He had a trach and it was clear and staff were providing trach care per physician's orders. V20 stated she expected nurses including agency nurses to be in-serviced/educated on emergent trach care including trach reinsertion because when a resident has a trach it is considered medically necessary for breathing and when a trach is dislodged for any reason it should be reinserted immediately because without it could lead the resident to having respiratory distress which could lead to brain death. V20 stated when she assessed R2 on 10/31/2025 she couldn't recall if there was an emergency trach reinsert kit in his room, but she expected there to be one in R2's room in case of dislodgement. V20 stated she expected staff to document resident's trach size in the resident's medical record so nurses would know what size to reinsert if the trach is dislodged. On 11/14/2025 at 12:25 PM V3, ADON stated the facility's trach care policy doesn't document instructions on how to reinsert a trach if it is dislodged and they have been in-servicing nurses using a trach care skills checklist this week, but it also didn't include trach (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	insertion instructions. V3 clarified the facility doesn't have a policy or skill checklist that covers trach reinsertion, so no staff have been in-serviced on trach reinsertion. V3 stated the facility is currently working on finding a trach skills checklist for trach reinsertion so they can in-service nurses on it. The Facility's Tracheostomy Care Policy revised 10/2024 documents, it is the policy of this facility that residents with tracheostomies receive routine care to maintain a patent airway. No documentation regarding trach reinsertion is addressed in the facility policy. The Facility's Facility Assessment dated 6/18/2025 documents the Facility provides care for COPD, pneumonia, asthma, chronic lung disease, and respiratory failure. Specialized Rehabilitation Services include Respiratory. Special Care Needs include tracheostomy care and ventilator care.The facility took the following actions to remove the immediacy and prevent any additional residents from suffering an adverse outcome. Completion dated: 11/14/2025. R2 no longer resides at the facility. All new trach patients have the potential to be affected by alleged deficient practice. All nurses will be in serviced by the DON/Designee on emergent and routine trach care initiated on 11/14/2025 & completed on 11/14/2025. Nurses will be inserviced prior to the start of their next shift. Agency nurses will be in serviced prior to the start of their next shift by the DON/Designee on emergent and routine trach care initiated on 11/14/2025 & completed on 11/14/2025.Actions to Prevent Occurrence/Recurrence: the facility took the following actions to prevent an adverse outcome from reoccurring. Trach inservicing - completed once a month for 3 months starting 11/14/2025 by the DON/Designee. Audit logs: - 3 nurses will be observed on trach competency weekly for 4 weeks by DON/Designee initiated 11/14/2025. QAPI Review: Committee will access outcomes and adjust training as needed weekly during QA and initiate 11/14/2025.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure kitchen employees had food handling certificates for 4 staff, 3 cooks (V38, V39, V40) and a dietary aide (V31). This failure has the potential to affect all residents in the facility.Findings include:On 11/18/2025 at 8:40 AM V30, Dietary Manager stated she started working as the dietary manager 2 months ago and she spoke to corporate, and they told her they were aware there are multiple kitchen staff that haven't taken the food handlers certification class and corporate set it up for all kitchen staff to attend an in person class in August 2025 but no kitchen staff attended the class. V30 stated V31, Dietary Aide told her he took the class, but she wasn't sure if he had or not.The Facility's Employee Census documents V31 is a DA (Dietary Aide) and hire date: 5/1/2025.On 11/18/2025 at 8:47 AM V31, Dietary Aide stated he thought he took the required kitchen certification but perhaps he hadn't.On 11/18/2025 at 1:00 PM V2, Director of Nurse (DON)/Administrator in Training (AIT) stated she couldn't find V31's food handler certificate.On 11/19/2025 at 11:40 AM V30 stated 2 cooks and 1 dietary aide are taking the food handler certification class today.On 11/19/2025 at 11:41 AM V2, DON/AIT stated 3 kitchen staff are taking the food handler certification classes online today and they will not work until they have the classes completed. V2 stated she wasn't aware the kitchen staff didn't have the food handler certifications completed.On 11/19/2025 at 12:00 PM V2 DON/AIT stated all kitchen staff hire date is 5/1/2025 because the dietary department was contracted by another company and on 5/1/2025 the facility took over the dietary staff, and she doesn't know any of the dietary employee's original hire date due to this.The Facility's Employee Census documents V39 is a [NAME] and hire date: 5/1/2025.On 11/19/2025 at 12:19 PM V39, [NAME] stated her initial hire date was 9/9/2024 and she has had 6 dietary mangers since she's started working at the facility. V39 stated on 9/25/2025 the former dietary manager informed her she needs to take the food handlers class to work in the kitchen but no one told her how or when to take the class then that dietary manager left and V30 didn't notify her of when or how to take the class either.On 11/19/2025 at 12:48 V30 stated there is another cook that doesn't have the food handler course completed which is V38 and she is completing it today. V30 clarified there are 3 cooks and 1 dietary aide that hadn't completed the food handler's course.The Facility's Employee Census documents V38 is cook and hire date: 10/14/2025.On 11/19/2025 at 12:52 PM V38, [NAME] stated her initial hire date was 10/11/2025 and no one told her she needs to take a food handlers class prior to working as a cook. V38 stated she has been a cook many years and she's taken the food handler's class before but she couldn't recall where she took the course, so she has to retake it.On 11/19/2025 at 1:00 PM V30 stated she has 2 cooks V38 and V39 and the dietary aide V31 taking the food handler class online today and she can't get ahold of V40, [NAME] to let him know to take the course as well.The Facility's Employee Census documents V40 is a cook and hire date: 5/3/2025.On 11/19/2025 at 1:45 PM V2 DON/AIT stated the facility does not have a policy on kitchen employees having the food handler certification course being completed but she expected all kitchen employees to have the certification completed.The Facility Daily Census Form dated 11/6/2025 documents 80 residents in the facility.