

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 01/22/2026
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide supervision to prevent elopement for 2 out of 2 residents (R2, R4). This failure resulted in R2 eloping through the front entrance at 2:05 AM unsupervised and the facility being notified of his location 4.4 miles away at 10:52 AM. This failure resulted in R4 eloping from the front door and being found across a busy two-lane road that borders the front of the facility approximately 500 feet away from the entrance at 1:27 PM. The Immediate Jeopardy began on 11/22/25 at 2:05 AM when R2 eloped through the facility's front door, R2 was not reported missing until six hours later at approximately 8:00 AM and found at 10:52 AM about 4.4 miles away from the facility in R2's wheelchair. On 1/15/26 at 3:40 PM, V1 (Administrator) was notified of the Immediate Jeopardy. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 1/16/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: 1. R2's face sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, aphasia, acute and chronic respiratory failure, dementia with agitation, major depressive disorder, schizophrenia, facial weakness following cerebral infarction and unsteadiness on feet. R2' Minimum Data Set (MDS) dated [DATE], documented R2 to be severely cognitively impaired, requiring partial/moderate assistance from staff to transfer from bed to chair/bed. R2 also utilizes a wheelchair and requires supervision or touching assistance to wheel 50 feet and when making two turns. R2 was unable to be interviewed due to dementia diagnosis. R2's Care Plan dated 6/1/23 documented R2 is at risk for elopement with interventions for staff as follows: on 6/1/23 incorporate diversional activities, on 6/8/23 friendly approach and wander guard as ordered on 6/15/23 redirect from exit doors and show him his room. R2's Care Plan dated 5/31/23 documented wander guard placement with the following interventions for staff to complete: check function of wander guard as ordered, monitor every shift for placement and proper function of wander guard, replace wander guard every 90 days and document location of replacement as ordered. R2's Care Plan dated 6/13/23 documented he requires assistance with daily care needs with an intervention to provide assistance with ADLs (activities of daily living). R2's Care Plan dated 6/13/23 documented he is at high risk for falls related to impaired safety awareness, use of psychotropic medication, incontinence, impaired balance/coordination with right side weakness. R2's Elopement Risk Assessments dated 12/29/23, 3/12/24, 6/11/24, 8/3/24, 8/17/24, 9/10/24, 12/10/24, 1/28/25, 3/28/25, 4/25/25, 6/14/25, 6/26/25, and 9/25/25 all rated R2 to be at high risk. The local Fire Department's Incident Report dated 11/22/25 at 9:12 AM documented, V6 (Deputy Chief) received a text message from Capt. (captain) stating that the facility was requesting access to our department camera system due to a missing resident. V6 responded to the station and was given contact information for the ADON, V3, who V6 spoke with by phone. V3 stated that a male PT (patient) was last accounted for at 0230 (2:30 AM) this morning and is</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145655	Facility ID: 145655 If continuation sheet Page 1 of 8

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>stations. On 1/13/26 at 4:04 PM, V4 stated she would expect nursing staff to be rounding on the residents at minimum of every 2 hours and more if required. V4 stated rounding consists of knocking on the door, checking on the resident, checking if they are breathing, safe, checking on IV's or tube feedings, indwelling catheters, wounds, their comfort, positioning and making sure the resident is seen. V4 stated she could not confirm a resident was safe if they were not seen, which is why they round. V4 stated she was not aware the front door did not alarm to the nurse's stations. V4 stated she expects staff to do their jobs. On 1/14/26 at 12:28 PM, V2 (DON) stated R2 loves to be up in the front of the building by the birds, talking to V23 (receptionist), going to the vending machines, eating in his room but does not like when other people are with him while he eats. V2 state R2 needs touching/hands on assistance with his ADLs, cannot transfer himself alone, is always in his wheelchair, has never seen him walk. V2 stated R2 was rated high risk for elopements because when he first got here, he made attempts to get out. V2 stated they placed the wander guard on him when he had originally made those attempts. V2 stated he was always trying to remove the wander guard and is not compliant with it. V2 stated she expects staff to make 2-hour rounds, putting eyes on the residents, and if they are not seen staff will report to the nurse and continue to look and follow policy. V2 stated there are elopement binders now at the nurse's stations with pictures of the at-risk residents and their medical conditions, also they have been in-servicing on elopements with all the staff including agency but prior to R2's elopement she is not sure what was being done or in place. V2 stated the aide should lay eyes on a resident if they haven't seen them and were told the last where abouts were 5 minutes ago. V2 stated R2 was up all night that night when another resident came in the front door at 2:00 AM. V2 stated she saw the camera footage of R2 going to the door before it was able to reset and pushed it open. V2 stated R2 was not wearing his wander guard, and no alarms went off. V2 stated the resident that returned put in the code himself with no staff to let him in and residents are not supposed to have the code. V2 stated they've had to change the code many times. V2 stated she's not 100% sure how the front door alarm works, V24 tried to explain it to me, just know it's a high traffic door. V2 stated she would have expected someone to have noticed R2 was gone between the 6 hours of 2:00 AM and 8:00 AM. V2 stated they cannot confirm R2's safety while he eloped. V2 stated R2 was not safe to be outside unsupervised he could have gotten hit by a car, which could have led to serious harm or death. V2 stated R2 was found near his old house which is now torn down. V2 stated R2 had no injuries. At 1:26 PM, V2 stated she was the first to get to R2 along with V24 after R2's old neighbor recognized R2 and called the facility. V2 stated R2 was sitting outside, no injuries noted. V2 stated R2 didn't want to leave and told her he was going to stay. V2 stated R2 told her he went to a fast-food place to get food also. On 1/15/26 at 9:54 AM, V2 (DON) stated her expectations for frequent monitoring entails every two-hour rounding for those needing close supervision that R2 was. On 1/15/26 at 9:48 AM, V24 (Maintenance Director) stated R2 didn't want to come back when they found him. V24 stated R2 rode back to the facility with the police. V24 stated R2's old neighbors recognized him and called us when he got out. V24 was the first one to get to R2 and he didn't look hurt in any way, he was feeling good and said he was going to stay there. V24 stated R2 didn't mention how he was able to get to where he was found but there's no way he got there on his own in his wheelchair and he must have been on concrete, no way he could get through grass in his wheelchair either. On 1/15/26 at 8:22 AM, V1 Administrator, stated the wander guard is what is put in place as an intervention for residents with concerns of supervision. V1 stated she will have someone supervising the front door 24 hours a day and the front door alarm can be heard from the back nursing stations. V1 stated there is no policy for rounding but our expectations were added to the daily staffing sheets</p> <p>(continued on next page)</p>		

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 01/22/2026
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>starting sometime in December she thinks which state every two-hour check/change/reposition for all rooms on assignment under CNA Duties. At 11:01 AM, V1 stated she wasn't at the facility during the initial investigation for R2 but the regional nurse at that time was in charge of it. V2 stated she didn't think to add interviews of any staff members that were working the night R2 eloped. V2 stated she did talk to the nurse on the phone but didn't type up the interview. On 1/13/26 at 3:44 PM, V26 Medical Director (MD) stated he cannot confirm someone's safety without seeing them. On 1/14/26 at 10:52 AM, V26 (Medical Director) stated there's a safety risk for R2 while he eloped. V26 stated you could not make sure R2 was safe from harm during the time he eloped. V26 stated R2 was not a high risk for elopement prior to his elopement and when questioned about R2 having been rated high risk prior, V26 stated he would have to defer to the facility on their assessment scores. V26 stated given the facility's expectations of rounding being done, he would have expected them to have seen him during those 6 hours. V26 stated R2 being outside in the middle of the night is a safety concern and supervision is necessary to keep him safe from harm. On 1/12/26 at 1:45 PM, Surveyor observed R2 sitting in his wheelchair at the front lobby by the bird cage looking out the window. R2 had a wander guard strapped to the back of his wheelchair. R2 stated he usually hangs out here, they won't let him leave and he's never left the facility or gotten out. R2 is unable to answer questions appropriately about his care. On 1/13/26 at 1:11 PM, V4 and V3 (ADON) took R2 near the front door with his wander guard in place. The alarm went off when R2 was within 6 feet of the front door. V3 then went outside and put in the door code, walked inside and waited 10 seconds before attempting to open the front door again and was unable to, it was locked. On 1/15/26 at 12:07 PM, staff held down front door handle for 15 seconds, the door unlocked and opened, the alarm sounded until deactivated by receptionist. 2. R4's Face sheet documented she was admitted on [DATE] with diagnosis of, in part, asthma, cognitive communication deficit, schizophrenia, and encounter for surgical aftercare following surgery on the digestive system. R4's MDS dated [DATE] documented her to be cognitively intact with hallucinations and delusions, requiring supervision with all transfers and walking. R4's Care Plan documented on 10/30/25 she was at risk for elopement related to her delusions, and stating intent to leave with interventions for staff as follow: on 10/30/25 1:1 with staff as needed, 15-30 min checks as needed, allow concerns to be expressed, check placement/function of wander guard every shift, replace wander guard every 90 day, may use wander guard to monitor resident for safety, encourage resident to keep busy with activities, MD notification PRN (as n</p>		