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	05/13/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement effective fall interventions for 1 of 3 residents (R2) reviewed for accidents in the sample of 7. This failure resulted on R2 falling 4 times, requiring to be sent to the hospital and receiving a laceration to her head. This past non-compliance occurred from 3/11/2026- 3/20/2026. Findings include:R2's progress noted dated 3/9/2026 documents R2 was admitted to the facility from assisted living.R2's face sheet date 5/7/2026 documents a diagnosis in part of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting Right dominant side, cerebral infarction, muscle wasting and atrophy right and left lower leg, weakness, reduced mobility, and abnormalities of gait and mobility.R2's Fall risk assessment dated [DATE] documents a score of 12 (score of 10 or above indicates high risk for falls)R2's Fall risk assessment dated [DATE] documents a score of 26.R2's fall risk assessment dated [DATE] document a score of 20.R2's fall risk assessment dated [DATE] documents a score or 23.R2's fall risk assessment dated [DATE] documents a score of 26.R2's fall risk assessment dated [DATE] documents a score of 29. R2's Minimum data set (MDS) dated [DATE] does not document any score of mental status. R2's MDS documents R2 is dependent on staff for toiletin, hygiene, upper and lower body dressing and persona hygiene.R2's care plan dated 3/9/2026 documents R2 is high risk for falls r/t falls since admission, impaired balance and gait, use of psychotropic meds and incontinence, impaired safety awareness glaucoma. R2's care plan documents the following interventions: 3-11-26 offer to lay out her clothing on bed/or chair, 3-17-2026 frequent rounding, 3-19-26 do not leave in room when she is up in chair, 3-19-26 pillows for positioning in wheelchair (she will not leave in place), 3/19/2026 refer to therapy for wheelchair positioning, 3-20-26 assist with leg rests in wheelchair as needed, 3-22-26 keep in high traffic areas when up in wheelchair, 3/15/2026: Move resident room closer to nurses station, 3/9/2026 Encourage and offer rest periods when walking long distances, Fall risk assessment quarterly and as needed, : Monitor for any changes in condition, Notify MD and family of any new fall, Therapy to evaluate and treat as indicated.R2's fall incident reports documents that R4 has had 4 falls at the facility.R2's fall incident report dated 3/11/2026 13:45 documents R2 attempted to ambulate to her closet and fell into the door which resulted in a laceration to R2's forehead. R2's fall report documents R2 was bleeding and lying on the floor. 911 was called and R2 sent out for evaluation. R2's fall report documents R2 was admitted to the facility in the past 72 hours. Report document R2's mental status as confused/forgetful. R2's fall report documents Behavior Interview Mental Status (BIMS) 2 - severely cognitively impaired. Intervention: offer to lay out R2's clothing for her.R2's Fall incident report dated 3/17/2026 at 14:06 documents R2 was found on the floor by Certified Nursing Assistant (CNA). Report documents when the nurse arrived R2 was lying on her left side propping herself up on left elbow. Report documents no obvious injuries. R2's fall incident report documents predisposing factors; confused, gait imbalance, impaired mobility and weakness. Report does not identify an intervention in place.R2's fall incident report dated 3/15/2026 at 14:40 documents resident on floor in her room. Report documents R2 fell out of her chair. Report documents R2 was sent out 911 for evaluation. R2's fall incident report (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	documents predisposing factors of confused incontinent, non-compliant with safety guidance gait imbalance and impaired memory. R2's report documents no injuries observed at time of incident. R2's report documents immediate action taken; interventions frequent rounding on resident and call before you fall sign. R2's fall incident report documents 3/18/2026 new intervention to move resident closer to the nures's station.R2's fall incident report dated 3/19/2026 at 18:30 documents R2 fell in the dining room during dinner and hit her head. Report documents when the nurse arrived R2 was lying on her back with a large bump to her forehead. Report documents 911 was called due to R2 being on anticoagulants, and lethargic. The report documents R2 fell forward out of wheelchair, when being taken to her room to lay down. R2's fall incident report documents mental status as confused. R2's report documents intervention: pillows for positioning in wheelchair. R2's fall incident report dated 3/22/2026 at 12:05 document R2 was found on the floor by roommates bed lying on her left side. Report documents no injuries at time. Report documents intervention: keep in high traffic areas when up in wheelchair. The facility policy Fall Prevention and Management dated, revised 1/2026 documents the facility is committed to maximizing each resident's physical, mental and psychosocial well-being. The policy documents while preventing falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. The policy documents all resident falls shall be reviewed, and the residents existing plan of care shall be evaluated and modified as needed. The policy documents upon admission a fall risk evaluation will be completed, readmission and quarterly, significant change and after each fall. The policy documents residents at risk for falls will have fall risks identified on the interim plan of care and the ISp with interventions implemented to minimize fall risk. ON 5/12/2026 at 12:35PM V10 Registered Nurse (RN) stated R2 was a sweet and confused lady. V10 stated R2 came from assisted living next door where she lived with her spouse. V10 stated R2 was admitted because she had a fall and was to receive therapy. V10 stated R2 was confused and acted like R2 did not know what to do. V10 stated R2 was a high fall risk on admission to the facility. V10 stated no interventions in place on admission except to remind R2 not to ambulate by herself. V10 stated R2 was eventually to be at nurses station because of falls. V10 stated she did not send R2 out to the hospital on 3/17/2026 after fall as no visible new injuries and R2 had a fall a couple of days before. V10 stated at that point it was determined R2 should be provided close observation. V10 stated R2 fell forward out of her wheelchair in the dining room on 3/19/2026. V10 stated R2's facial bruising got worse as R2 had another fall. V10 stated R2 had black eyes.On 5/12/2026 at 1:04PM V15, Assistant Director of Nursing (ADON) stated R2 had previously lived at assisted living with spouse and had a fall prior to admission V15 stated R2 was a known fall risk prior to admission to the facility. V15 stated R2 had 4 falls at the facility. V15 stated R2 was confused.On 5/13/2026 at 11:50AM V19, physician per telephone interview stated he would expect the facility to have interventions in place for R2 on admission, since R2 fell prior to admission. V19 stated he would expect the facility to identify and implement effective fall interventions. Prior to the survey dated 5/7/2026 the facility took the following actions to correct the non-compliance: Education on fall prevention policy provided 3/20/2026.R2 fall care plan reviewed and revised to meet resident needs on 3/20/2026.Director of Nursing (DON)/ Designee will audit falls facility activity reports daily for any residents who exhibit sexual behaviors 5 times weekly x 4 weeks, then 3x week for 4 weeks and then random thereafter to ensure root cause analysis and appropriate interventions are in place on 3/19/2026The Administrator/ADON/Designee will review all new admission fall risk assessments 5 times a week for 4 week, 3 times a week for 4 weeks and randomly thereafter to ensure appropriate measures are in place on 3/19/2026.A QAPI has been initiated to report the above monitoring and auditing procedures. All findings from the QAPI/PIP will be presented to the monthly QAA meeting. Monitoring/ auditing and reporting will continue for a minimum of three months Administrator/ Designee will conduct random staff and resident interviews 3x weekly x 4 weeks focusing on any reports of potential abuse.