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	07/02/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent abuse for 1 of 3 residents (R2) reviewed for abuse in a sample of 8. Findings include:1. R2's Care Plan, dated 3/5/2023, documents that ABUSE: At risk for abuse and neglect r/t (related to) psychotropic meds, behaviors toward staff, dx (diagnosis) schizophrenia.R2's Minimum Data Set, dated [DATE], documents that R2 is moderate cognitive impaired and requires assistance with Activities of Daily Living (ADL).R2's Other Report, dated 6/4/2026, documents that Nursing Description I, (V5), LPN (Licensed Practical Nurse), was doing medication administration when I witnessed (R3) (resident) walk pass another resident using wheeled walker, he stepped on the foot of (R2). (R2) began yelling and stating his foot had been stepped on. R2 is oriented to person, confused/forgetful and unable to give a description of event.R2's Nurses Notes, dated 6/9/2026 12:19 PM, documents that Note Text: New order rec'd per (V8), NP (Nurse Practitioner), for STAT 2-view x-ray to Residents left foot R/T (related to) C/O (complaints of) pain, foot stomped on by another Resident. No edema to the left foot noted. States tender to touch on the top of his foot. Called (x-ray company) and spoke with [NAME]. Ordered x-ray STAT.R2's Left Foot X-Ray, dated 6/9/2026, documents reason Pain, and left foot stomped on. Findings: mild soft tissue swelling. No evidence of recent fracture. On 7/2/2026 at 9:20 AM V5, LPN, stated that she was passing her medication on the hall. V5 stated that R2 was sitting in the hall but against the wall. V5 stated that she looked up from the cart to see R3 with his leg raised and then stumped on R2's foot. V5 stated that she observed R3 come down with force on top of R2's foot. V5 stated that she separated them and R3 started laughing. V5 stated that she reported the incident to (V1) and made a police report.On 7/2/2026 at 9:29 AM R2 stated that he is blind and did not see what happen. R2 stated that he remembers the pain. R2 stated that he was in a lot of pain. R2 stated that he remembers having the x ray. R2 stated that he was not sure if he was safe at the facility. R2 stated that sometimes he feels safe and sometimes he doesn't.On 7/2/2026 at V7, Registered Nurse, stated that she was made aware of another resident stomping on R2's foot. V7 stated that they were monitoring it because R2 was complaining of pain in the foot and of it being tender to touch. V7 stated that she did not see a bruise but there was some slight swelling. V7 stated that she V8 were keeping an eye on it and when R2 continued to complain of pain V7 requested an x ray to make sure there was more of an injury.2. R3's Care Plan does not address R3's behaviors towards staff or residents. R3's MDS, dated [DATE], documents that R3 is cognitively intact.R3's Nurses Notes, dated 6/4/2026 7:14 PM, documents that Late Entry: Note Text: I, (V5), LPN (Licensed Practical Nurse), was doing medication administration when I witnessed (R3) (resident) walk pass another resident using wheeled walker, stomped on the resident's foot, and proceeded to laugh. I, (V5), Redirected (R3) away from the resident after the incident. Incident was reported to (V1), Administrator and a police report was made with Officer (V6).R3's Acute Care Note, dated 6/9/2026 at 11:36 AM, documents that Visit Type: Acute Care: I saw and examined this patient on rounds today for acute concern of: behavior. Resident is ambulating in halls, NAD. Resident denies any acute concerns, staff reports resident has been intoxicated for days now. Resident often leaves LOA (leave of absence) and returns with ETOH (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
	145655	A. Building B. Wing	07/02/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(alcohol) and/or after abusing it. Resident acts erratically when drinking and uses inappropriate language with staff. It was reported that resident stomped on another resident's foot the other day. Resident endorses this action however reports thinking 'it was funny'. The police were notified according to staff.The facility's Long-Term Care Facility & 110 - Serious Injury Incident and Communicable Disease Report, dated 6/10/2026, documents that Incident category Physical Altercation. It also documents that R3 is a long-term care resident of the facility. He has a BIMs (brief interview of mental status) of 15, he is able to ambulate throughout the facility and make his needs known. He has the following diagnosis: Osteonecrosis; weakness; muscle weakness; essential HTN; hyperkalemia; hidradenitis suppurative. R2 is a long-term care resident of the facility. He has a BIMs of 11, he is able to verbalize his needs and requires staff to propel him throughout the facility. He has the following diagnosis: COPD; hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side; schizophrenia; personal history of TBI; other epilepsy; dysphagia following cerebral infarction. R2 was sitting in his wheelchair in the 300 hall. He had pushed himself into the main walkway facing his room. Another resident was on the left side of the hall near resident R2. R3 was ambulating down the hall and was attempting to get around resident R2. When going past he picked his walker up and was going around and stepped on resident R2 foot. The investigation was conducted by staff and resident interviews. Care plans reviewed and updated. Resident R2 had x-ray to left foot. Both residents feel safe in the facility. Though this event did occur, it did not rise to the level of abuse. This incident is unsubstantiated.R3's 30-day Follow up Note, dated 6/3/2026 at 9:05 AM, documents that visit Type: 30-day Follow up. It also documents R3's F10.929 - Alcohol use, unspecified with intoxication, unspecified. Patient frequently leaves the facility and returns intoxicated, exhibiting belligerent and non-adherent behavior toward staff and residents.On 7/2/2026 at 7:52 AM R6, President of Resident Council, R6 stated that R3 has been yelling at other residents in the facility. R6 stated that she is not sure if he is drunk. R6 stated that R3 screams and curses at other residents in the facility. R6 stated that R3 has not approached her but has approached others. R6 stated that she does not always feel safe at the facility. R6 stated that at night there are yelling and screaming at times and there are minimal people to help you. R6 stated that the facility had her fill out a form asking if she feels safe and she put not all the time.The facility's Abuse policy, dated 9/2017, documents that Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. It also documents that This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.