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	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Woodriver	393 Edwardsville Road Wood River, IL 62095

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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	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 observation, interview, and record review the facility failed to initiate and implement progressive interventions to prevent falls for 3 of 10 residents (R2, R19, and R51) reviewed for falls in a sample of 41.Findings Include: 1)R2's Undated Face Sheet documents R2 was admitted to the facility on [DATE] and has a medical diagnosis of reduced mobility, muscle weakness, difficulty in walking, dementia, abnormalities of gait and mobility, and repeated falls. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is severely cognitively impaired, uses a wheelchair, needs substantial/maximal assistance with sitting to standing and chair/bed to chair transfers. R2's Care Plan Date Initiated 3/30/2025 documents Fall: R2 is at high risk for falls related to incontinence, weakness, history of fall, glaucoma, confusion, and use of psychotropic meds. Intervention Date Initiated 8/10/2025 documents out to er. Intervention Date Initiated 11/13/2025 documents brightly colored reminder on wheelchair to not stand up without assist. R2's Care Plan was reviewed in its entirety as viewed in R2's Electronic Health Record. R2's Care Plan Date Initiated 5/8/2025 Transferring: R2 has a self care deficit in transferring related to impaired balance, weakness. R2's Quarterly Fall Risk Evaluation Dated 7/22/2025 documents R2 is a high fall risk. R2's Nurses Notes dated 8/10/2025 at 11:33 PM documents patient sent to Local Hospital related to falling in room trying to take himself to the bathroom. Complaining of 10/10 pain, barely able to move around from the pain. Survival flight called for transportation and took patient to hospital. The Facility's Fall Investigation for R2's Fall dated 8/10/2025 contains R2's Face Sheet, Physician Orders, Care Plan, and Minimum Data Set Section O (Special Treatments, Procedures, and Program, Section C (Cognitive Patterns, Section GG (Functional Abilities (Admission), Section GG (Functional Abilities- Discharge). No root cause analysis or intervention noted. R2's Local Hospital XR Pelvis 1 or 2 views dated 8/11/2025 documents impression: intertrochanteric fracture of the right hip R2's Nurses Notes dated 8/13/2025 at 6:48 PM documents resident readmitted to facility at this time for post right hip fracture after fall, surgically replaced. R2's Nurses Notes dated 11/13/2025 at 10:48 AM documents 0902 Resident was in wheelchair sitting (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at nurses station with staff present. Resident continued to try and stand and was redirected to stay in his wheelchair. As staff member turned her back resident stood and fell into medication cart hitting the back of his head and shoulder on the wheel of the medication cart. Resident denies any pain associated with fall. Resident assisted back to wheelchair with use of gait belt and two assist transfer. Nurse Practitioner stated to send resident to hospital as resident hit head and is on blood thinner. R2's Nurses Notes dated 11/16/2025 at 5:36 PM documents the resident arrived at the facility at 14:00 on a stretcher, accompanied by Emergency Medical Technicians (EMTs) x2 from Local Hospital. The resident was alert and oriented x2, but exhibited some discomfort when moved, related to a fractured clavicle on the left side. The left arm is currently in a sling that should be worn while up. R2's Nurses Notes dated 11/17/2025 at 10:33 AM documents resident was sitting by nurses station, partially down hall. resident states that he was trying to go to the bathroom and fell while ambulating without assistance. Fall was unwitnessed. Resident is complaining of left hip pain. pain check, range of motion (rom), skin check, Neuro check, vital signs obtained. resident sent to local hospital. R2's Nurses Notes dated 11/17/2025 at 11:01 AM documents resident was sitting at nurses station, partially down 500 hall. resident then attempted to stand without assistance, was unwitnessed, resident then fell to the floor. resident complaining of left hip pain. resident sent to local hospital for evaluation. R2's Local Hospital XR Hip Left 2 or 2 views with pelvis dated 11/17/2025 documents Pelvis/left hip: there is a comminuted fractur of the intertrochanteric proximal left femur with moderate displacement of the lesser trochanter fragment and mild displacement of the main distal fracture fragment. R2's Nurses Notes dated 11/18/2025 at 10:20 AM documents This nurse called local hospital to get an update on this resident. Resident is currently awaiting surgery on hip. R2's Nurses Notes dated 11/20/2025 at 6:15 PM documents resident returned to facility at this time, alert and oriented to self, has visual hallucinations upon arrival. hospital states that he had visual hallucinations at hospital as well. he's returning with left l(t) hip fracture (fx) with surgical repair, also has a recent lt clavical fx, prior to this hospital stay. On 2/6/2026 at 9:33 AM R2 observed trying to stand up without assistance from his wheelchair in front of nurses station. No brightly colored reminder to not standup without assist noted to R2's wheelchair. On 2/13/2026 at V22, MDS Coordinator, stated after a resident experiences a fall, the facility will investigate the fall, determine a root cause analysis for the fall, and implement an intervention for the fall. V22 stated the resident's care plan is updated with an intervention after each resident fall. On 2/13/2026 at 9:18 AM V13, LPN, stated R2 is a high fall risk and use to always try to get up on his own and would fall. V13 stated R2 requires assistance with transferring. On 2/13/2026 at 9:29 AM V2, Director of Nursing, stated she expects the facility to implement a fall intervention and update the resident's care plan with the intervention after every fall. On 2/13/2026 at 9:51 AM V18, Nurse Practitioner, stated she expects the facility to follow their fall (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	policy and implement interventions for residents to help with falls. On 2/13/2026 at 11:00 AM V23, Certified Nursing Assistant, stated R2 has had falls and requires assistance with getting up and transfers. 2. R51's EMR (Electronic Medical Record) undated documents that the resident was admitted to the facility on [DATE]. R51's EMR dated 3/27/24 documents a diagnosis of Cerebral Infarction, unspecified. R51's EMR dated 2/28/25 documents a diagnosis of Difficulty in walking, not elsewhere classified. R51's EMR dated 6/17/25 documents a diagnosis of Repeated Falls. R51's MDS 12/5/25 documents a BIMS score of 14 out of 15. The MDS documents that the resident requires supervision or touching assistance for roll left and right. The MDS documents that the resident requires partial/moderate assistance for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer. R51's Care Plan dated 3/6/25 documents FALL: high risk for falls r/t (related to) incontinence, impaired balance, history of fall, psychotropic meds. Interventions: 3-12-25 - non-skid strips by bed. 3-22-25 - toileting pgm (program). 3-6-25 - low bed when arrives. 4-10-25 - assist with gripper socks. 4-14-25 - non-skid strips by toilet. 4-20-25 - keep in high traffic area. 5-17-25 - anti roll backs when arrives. 5-31-25 - dycem in wheelchair. 6-18-25 - gripper socks when up in chair. 6-22-25 - grab bars x's 2 assist with positioning and transfers dc'd (discontinued) 11-21-25 changed to half rail on right side. 7-13-25 - Keep frequently used items within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7-14-25 - clinical evaluation. 7-26-25 - leave wheelchair in locked position by bed. 8-10-25 - no cloth pads in wheelchair. 8-22-25 - wheelchair seat modified. 8-25-25 - encourage participation in afternoon activities. 8-8-25 - bed against wall. 9-3-25 - Brightly colored visual aid on call light. 10-5-25 - remind to ask for assist with standing. 11-15-25 - brightly colored reminder on wheelchair not to stand without assist. 11-15-25 - therapy to eval. 11-24-25 - frequent observation and assist to have gripper socks in place. 11-27-25 - Staff to remind resident to sit up straight in wheelchair. 11-9-25 - Encourage AM diversional Activity, involve in activity of choice. 12-11-25 - toileting pgm to be modified. 12-30-25 - call before you fall sign by bed. 12-31-25 - redirect to hall as needed. 1-13-26 - re-educate on wheelchair positioning. 1-17-26 - dycem under resident in chair and under pad chair. 1-23-26 - during rounds staff to observe for covers to be straight. 1-26-26 - given reacher. 1-27-26 - therapy to eval for wheelchair saddle cushion. R51's Nurses Notes dated 3/6/25 at 9:33 PM documents Resident was put into his bed this evening. When the CNAs (Certified Nursing Aid) went to check on him, he had his diaper off, knees on the floor with the rest of his body lying on the bed. The CNAs got him off the floor and into his bed, and re-educated him to stay in bed, because it's nighttime. He then began to scoot his feet and legs back to the side of the bed. I retrieved a fall mat and placed it on the side of his bed. Plan of care ongoing. R51's intervention dated 3-12-25 documents non-skid strips by bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/10/26 at 1:13 PM, observation of R51's room. No non-skid strips noted by R51's bed. R51's Nurses Notes dated 4/10/25 at 4:21 PM documents res (resident) was found sitting on floor mat, no injury/pain noted at this time. Will continue to monitor. VS (Vital signs) WNL (Within Normal Limits). R51's intervention dated 4-14-25 documents non-skid strips by toilet. On 2/10/26 at 1:13 PM, observation of R51's room. No non-skid strips noted by R51's toilet. R51's Nurses Notes dated 7/26/25 at 2:12 PM documents Resident was trying to transfer from his bed to the chair in his room unaided and fell on his buttocks. This nurse along with other staff assisted him to his bed. Resident was assessed, no physical injuries noted. Vital signs checked BP (blood pressure) 126/68 P (pulse) 60. R51's Intervention dated 7-26-25 documents leave wheelchair in locked position by bed. On 2/10/26 at 1:13 PM, observation of R51's room. R51's wheelchair was noted to be across the room from resident's bed. R51's Nurses Notes dated 11/27/25 at 4:10 PM documents At 1555, this nurse observed Resident slide from his w/c (wheelchair) to the floor onto his buttocks. Did not hit his head. Assessment completed. Hand grips are strong and equal bilaterally. PERRL (Pupils Equal Round Reactive to Light). ROM (Range of Motion) WNL per baseline. Denies any pain or discomfort. VSS (Vital signs Stable). Assisted Resident using gait belt and two assists back to his w/c. Director of Nursing notified. R51's Intervention dated 11-15-25 documents brightly colored reminder on wheelchair not to stand without assist. On 2/10/26 at 1:13 PM, observation of R51's room. No brightly colored reminder noted on R51's wheelchair. R51's Nurses Notes dated 12/30/25 at 4:45 PM documents At 1625, CNA called this nurse to Residents room. Observed Resident sitting on the floor in front of his w/c next to his bed. Resident stated he was being stubborn and tried to transfer himself from his w/c to his bed. He denied hitting his head. Denied pain. Head to toe assessment completed. No apparent injuries. No changes in cognition. Hand Grips strong and equal bilaterally. ROM WNL per baseline. PERRL. Resident w/c was not locked. His call light was within his reach. Had on non-skid shoes. Y (temperature) 97.3HR (heart rate) 59 RR (respirations) 18 BP 129/50 SpO2 (oxygen saturation) 97% on RA (room air). Assisted back to his w/c. R51's Intervention dated 12-30-25 documents call before you fall sign by bed. On 2/10/26 at 1:13 PM, observation of R51's room. No call before you fall sign noted by resident's bed. R51's Nurses Notes dated 1/23/26 at 3:00 AM documents This nurse was notified by cna that resident was on the floor. When asked what happened? Resident stated he was tossing and turning in his sleep when he noticed he was on edge of the bed it was too late so he scooted to floor. VS T 98.6 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bp 114/55 R 18 P 66 spo2 96% RA. ROM WNL. No injuries no c/o (compliant of) pain. Resident assisted back into bed via (mechanical lift) with assist of 2. Resident in bed at thus time resting. R51's Intervention dated 1/27/26 documents given reacher. On 2/10/26 at 1:13 PM, observation of R51's room. No reacher noted in resident's room. On 2/13/26 at 9:41 AM, V2, DON (Director of Nursing) stated that care plan interventions should be implemented after the facility determines the appropriate fall intervention for the resident. 3-02/05/2026 10:33 AM R19 stated she had just fell a day ago and her ankle still hurts. R19's POS dated January 2026 documents a diagnosis of Type 2 diabetes mellitus, weakness, unsteadiness on feet, cognitive communication deficit, acute kidney failure, chronic kidney disease stage 3, muscle weakness, heart failure, hypertension, generalized anxiety disorder, depression, anemia, insomnia. R19's MDS dated [DATE] document R19 was severely impaired for cognition for activities of daily living. R19's Progress Notes dated 2/3/2026 at 2:28 PM, Resident was trying to get into the bathroom in her wheelchair and fell to the floor. The resident claimed she landed on her right side and that her ankle hurt. This nurse assessed her and there were no open wounds or bruises. The hall CNA's (certified nursing assistants) aided the resident into the wheelchair. This nurse asked if there was any pain, and she claimed there was pain in her right ankle and right hip. Vital signs were within range. R19's Care Plan with a date initiated of 1/15/2025 documents under Fall: is at risk for falls r/t (related to) frequent falls, impaired safety awareness, impaired balance and gait, incontinence. R19's Care Plan dated 3/17/2025 documents, frequent rounding during the day. (No interventions were documented for R19's fall on 2/3/2026. On 2/6/2026 at 11:48 AM, R19's Fall Report and investigation was requested to V1, Administrator. On 2/6/2026 at 4:30 PM, R19's Fall report and investigation information was requested from V1, Administrator. On 2/7/2026 at 10:10 AM, R19's Fall report and investigation was requested from V1. On 2/7/2026 at 3:30 PM, a green folder with R19's POS, Care Plan and nurse's notes were provided by V2, Director of Nursing (DON). On 2/7/2026 at 3:35 PM, V2, Director of Nursing (DON) stated that was everything they had for R19's fall. R19's folder did not contain any interventions and/or anything addressing her fall other than the progress note for her fall on 2/3/2026. The Facility Fall Log documents R19 had a fall on 2/3/2026, No other falls were documented for R19 for the past six months. On 2/10/2026 at 12:44 PM, V1, Administrator stated policy she expects all fall interventions to be (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	documented in the Resident's Care Plans. The Facility Fall Policy with a review date of 10/2018 documents, The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe as an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. Evaluate the resident for any injury and notify the physician and emergency contact. Complete a fall incident report in the (Computer) risk management portal. Care plan to be updated with a new intervention based on root cause analysis after each all occurrence.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide catheter care, including irrigation, in 1 of 5 residents (R75) reviewed for bowel/bladder incontinence, catheter, and UTI (Urinary Tract Infection) in the sample of 41. This failure resulted in R75 being hospitalized for a UTI.Findings Include:On 2/5/26 at 1:43 PM, R75 was observed in his room with a suprapubic catheter draining clear tea colored urine. R75 stated he has a suprapubic catheter, he does not take care of it himself, the staff cleaned it two or more days ago and he has had a recent urine infection. On 2/10/26 at 12:25 PM, R75 stated he was sent to the hospital about a month ago because his catheter was clogged up and it had to be replaced. R75 stated the staff only clean his catheter site every 2-3 days. Catheter care was observed with V5, Wound Nurse, and R75 complained of penile pain and tenderness around the suprapubic catheter site. R75's Face Sheet, undated, documents R75 has the following diagnoses: UTI, Sepsis, and Obstructive/Reflux Uropathy. R75's MDS, dated [DATE], documents the following: R75 has a BIMS (Brief Interview of Mental Status) score of 14, indicating R75 is cognitively intact, he requires partial/moderate assist with toileting, and has an indwelling urinary catheter. R75's Care Plan, dated 9/21/25, documents R75 has a suprapubic catheter. R75's (POS) Physician Order Sheet documents an order dated 1/30/26, to flush suprapubic catheter with 60cc (cubic centimeters) of sterile water every 12 hours. There were no orders for R75's catheter or catheter care. R75's Progress Note, dated 1/9/26 at 10:10 PM, documents R75's suprapubic catheter was changed. R75's Progress Note, dated 1/15/26 at 4:46 PM, documents the following: This nurse obtained the residents' vital signs and received a blood pressure of 200/152. This nurse attempted to contact telehealth with no answer. This nurse contacted the DON (Director of Nurses) who instructed this nurse to send the resident to the hospital. EMTs (Emergency Medical Technician) arrived at 4:40 PM and took the resident to the hospital. R75's Progress Note, dated 1/17/26 at 6:39 PM, documents the following: Resident arrived back to facility via ambulance accompanied by two on a stretcher. Resident arrived with a change in orders and some new orders, there are some follow-up appointments as well, which will be adjusted accordingly. Kitchen staff made aware of patients return to facility. No c/o (complains of) pain or discomfort. Resident is up, alert and oriented x4 to person, place, situation, and month. Resident in room with call light in reach awaiting food tray. Vital signs are as follows: 128/68; 97%; 98.9; 16; and 78. R75's Progress Note, dated 1/18/26 9:09 PM, documents the following: Resident currently on ABT (antibiotic) for UTI. Metronidazole 500 mg (milligrams) PO (by mouth) TID (three times daily) for 3 days, with the first dose being administered at bedtime, tolerated well. Foley catheter in place, patent draining yellow urine, and denies pain/discomfort at this time. R75's Progress Note by V18, Nurse Practitioner, dated 2/9/26 at 12:36 PM, documents the following: Obstructive and reflux uropathy, unspecified. Benign prostatic hyperplasia with lower urinary tract symptoms. Chronic indwelling suprapubic foley catheter for urinary retention. Foley, patent and draining. Oxybutynin ER (extended release) 5mg QAM (every morning) for overactive bladder, no current antibiotics, recent levofloxacin for UTI, now completed on 2/5/26. High risk for UTI: monitor for fever, confusion, dysuria, foul-smelling/dark urine.UA (urinalysis) ordered if symptoms arise. Regular assessment for pain (recent penile pain, managed with acetaminophen as needed). Nursing Care - Routine catheter care per protocol. Perineal hygiene reinforced. Foley care provided each shift. Catheter output and urine color monitored (recently straw-colored, no odor, no discomfort). Recent Complications - UTI treated with metronidazole and levofloxacin (Jan/[DATE]). No current signs of infection. Acetaminophen 500 mg PRN (as needed) for pain (recent penile pain episodes, responsive to medication). Notify provider for new/worsening confusion, pain/burning with urination, odorous/foul-smelling urine, or dark urine. R75's Progress Note, dated 2/9/26 at 5:53 PM, documents the following: Resident has had loose stool, brown in color, odor noted. Alert and oriented (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	x3, confused about the day and time. Skin warm and dry, color pale. Lungs clear x4. Vitals obtained 113/64, pulse 98, Resp 19, non-labored. temp 98.0, o2 sat 96%. Unable to stand, unsteady, poor balance. Sitting up in bed head elevated. PO fluids encouraged. Suprapubic catheter intact, patent, amber urine. R75's Progress Note, dated 2/9/26 at 6:13 PM, documents the following: Collected the stool sample, placed in the refrigerator. Spoke with NP (Nurse Practitioner), new orders to collect a urine sample, r/t (related to) resident complaining of burning, and pain. NP will place order for antibiotic to be started after the UA is collected. R75's Progress Note, dated 2/9/26 at 7:57 PM, documents the following: Pinched off the suprapubic catheter for one hour, collected urine sample, cloudy yellow urine with no odor, placed in refrigerator. R75's Hospitalist History and Physical, dated 1/22/26, documents the following: Assessment: Catheter associated UTI. Urine culture: greater than 100,000 CFU (colony forming unit) of pseudomonas aeruginosa and enterococcus faecalis. R75's MAR/TAR (Medication Administration Record/Treatment Record) document R75's catheter was last changed on 1/9/26. There was no documentation of catheter care or irrigation of the catheter for January or February 2026. On 2/10/26 at 12:25 PM, catheter care was observed on R75 with V5, Wound Nurse, and during care R75 complained of penile pain and tenderness around the suprapubic catheter site. On 2/10/26 at 1:36 PM, V19, LPN (Licensed Practical Nurse), stated R75 is supposed to get his catheter irrigated every 12 hours and she believes it is done on evening shift, she doesn't do it on the day shift. On 2/10/26 at 12:25 PM, V5, Wound Nurse, stated catheter care should be done every shift. On 2/10/26 at 2:12 PM, V2, DON (Director of Nurses) stated catheter care/irrigation of the catheter would be documented on the MAR/TAR. On 2/13/26 at 9:40 AM, V2, DON, stated she would expect physician orders to be followed. On 2/13/26 at 9:53 AM, V18, Nurse Practitioner, stated in part she would expect the nurses to use their nursing judgement when following physician orders. The Foley Catheter Care Policy, dated 4/2019, documents daily and PRN catheter care will be done to promote comfort and cleanliness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure food was stored and prepared in a manner which prevents potential contamination. This has the potential to affect all 76 residents living in the facility. Findings include: Facility [NAME], [NAME] (35156) - Kitchen On 2/5/2026 at 8:14 AM, in the walk-in refrigerator there was large industrial mesh bag of onions (50 pounds) sitting directly on the floor. In the corner was a large box of pasteurized eggs sitting directly on the floor. The eggs were next to a box of cupcakes and in the middle was a large industrial box of raw meat (chicken or pork) thawing. On 2/5/2026 at 8:15 AM, in the walk-in refrigerator on the metal shelf was a large industrial bowl of greens that was not dated and or labeled. Next to the bowl of greens was a bag of mozzarella cheese half opened and not covered sealed or labeled. The cheese was being exposed to the air. On 2/5/2026 at 8:16 AM, in the walk-in refrigerator on the metal shelf was a box of raw chicken that was thawing and dripping sitting next to a box with 12 heads of fresh cabbage inside the box. The boxes were next to each other. The chicken was not dated and or labeled. On 2/5/2026 at 8:18 AM, in the middle of the storage room there was a removable metal cart. On top of the cart was a large industrial size slab of beef thawing. The meat was not in a container but directly sitting on top of the cart. Underneath the cart was large industrial 4-quart container of a red substance with large noodles in it. The container sitting directly underneath the meat was not dated and or labeled. On 2/5/2026 at 8:20 AM, in the kitchen area is a large storage container and after opening the lid inside is a large industrial bag (25-pound bag) labeled breadcrumbs that was opened. The outside container was not dated and or labeled. On 2/5/2026 at 8:21 AM, in the kitchen area is large industrial container of food thickener that was not dated and or labeled. On 2/5/2026 at 8:24 AM, in the dry storage area is a large container of oatmeal sitting directly on the floor. The oatmeal is opened and exposed to the air. On 2/5/2026 at 1:03 PM, V7, Dietary Manager stated I would expect all items to be stored at least six inches off the floor and never stored directly on the floor. I expect all items to be dated and labeled and I expect meat to be stored alone and not near any other items to prevent food contamination and possible food borne illness. RR The Facility undated Food Storage Policy documents, Food stock and products are stored 6 inches of the floor (per state regulation) in the storeroom, walk-in cooler, and freezer. The Facility Labeling and Dating policy undated documents, Policy: Leftovers and opened foods shall be clearly labeled with. date food item is to be discarded. Food items to be labeled and dated include items prepared in house and food items that are opened and stored for later use. (i.e. salad dressings, pickles, etc.) Name of food item if not clearly identified on container. Discard date [NAME].e. opened 4/30, discard 5/30). (Need meat policy). All protein items (i.e. meat, poultry, fish) are defrosted under ref bottom shelf.

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	145655	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Woodriver	393 Edwardsville Road Wood River, IL 62095

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure call lights were being answered in a timely manner for 6 of 14 residents (R16, R17, R43, R67, R69 and R81) reviewed for call lights in the sample of 41. Findings include: 1-R67's MDS dated [DATE] document R67 is cognitively intact for decision making of activities of daily living. R67 uses a wheelchair and needs substantial/maximal assistance-Helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. During the Group Meeting on 2/5/2026 at 1:30 PM, R67 stated there were issues and have been complaints about the call lights not being answered in a timely manner. This is being brought up constantly at the Resident Council Meeting and does not seem to be getting any better. We typically wait for call lights at least 30 minutes if not more. 2-R16's MDS dated 11/2025 document R16 is cognitively intact for decision making of activities of daily living. During the Group Meeting on 2/5/2026 at 1:35 PM, R16 stated she was able to do most things by herself, but she attends the Resident Council Meetings regularly and this is something residents are constantly bringing up. We have issues with staff who really do not want to work and they are on their phones a lot and do not answer the call lights. It's a problem. 3-R43's MDS dated [DATE] document he was moderately impaired for cognition. During the group Meeting on 2/5/2026 at 1:39 PM, R16 stated there are times when he needs help with going to the bathroom and he feels embarrassed when he wets the bed and waits so long, he has an accident. Staff are not answering the call light fast enough when he needs to go to the bathroom. 4-R17's MDS dated [DATE] documents she is cognitively intact for decision making of activities of daily living. R67 uses a wheelchair and has impairment on her lower extremities and needs partial to moderate assistance with hygiene, dressing, showers and toileting. During the Group Meeting on 2/5/2026 at 1:42 PM, R17 stated that there are issues with staff not wanting to work and not answering the call lights. It's not uncommon for her to have to wait forty minutes for someone to answer her call light especially at night. 5-R69's MDS dated [DATE] document R69 was moderately impaired for cognition. On 2/5/2026 at 3:00 PM, R69 stated there are always issues with staff not wanting to work and not answering the call lights. It's a big problem here. 6-R81's MDS dated [DATE] document R81 was cognitively intact for decision making of activities of daily living. On 2/13/2026 at 3:00 PM, R81 stated that when she needs help, she does not always get help, and the staff are really bad about not answering call lights. She easily waits over an hour for staff to respond and sometimes that is way too long. This has caused her stress and when you need help you need help. On 2/13/2026 at 1:30 PM, V17, Ombudsman stated she had been getting a lot of complaints and has been out to the facility several times regarding call lights not being answered in a timely manner and it still seems to be a problem. The Resident Council Meeting Minutes dated 3/20/2025 documents, Call lights on for over an hour at time before being answered. The Resident Council Meeting Minutes dated 4/24/2025 documents, Call lights on for over an house at times before being severed. The Resident Council Meeting Minutes dated 11/20/2025 documents, Call lights are not being answered in a timely manner. Call lights are on for over an hour at times-All shifts. Grievance dated 8/5/2025 We see nurses and CNA's (certified nursing assistants) sitting at desk while call lights phone is ringing and doorbell is going off up front and they continue to sit there and talk. Grievance dated 3/20/2025 Call lights on for over an hour at times before being answered. Grievance dated 9/25/2025, Council believes nurses should help answer call lights when there are a lot of lights going off/doorbells ringing. Not just aides. Grievance dated 10/30/2025, Call lights are not being answered in a timely manner, Call lights are on for over an hour at times-All shifts. On 2/13/2026 at 2:41 PM, V2, Director of Nursing stated she expect all staff to answer call lights in a timely manner. She was aware of some complaints, but when we looked into it and we did find some call lights were not working properly. I expect call lights to be answered as quickly as possible less (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than 10-15 minutes.The Call Light Response Policy dated 9/2025 documents, To provide the staff with guidance on responding to resident's request and needs. Answer the patient or resident's call as soon as possible.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to properly label medications for an unknown number of residents due to medications not being labeled in a sample of 41.Findings include:On 02/05/2026 at 8:10 AM the 100 Hall Medication Cart was inspected with V8, Registered Nurse (RN). In the top right drawer of the medication cart, 2 Breztri Inhalers and 1 Airsupra Inhaler were observed with no resident name or date opened. 1 Breztri inhaler noted to have 1 inhalation left, 1 Breztri inhaler noted to have 8 inhalations left, and the Airsupra inhaler noted to have 10 inhalations left.On 2/5/2026 at 8:13 AM V8, RN, stated she did not know whose inhalers those were, and the inhalers looked like they have been used. V8 stated all inhalers should be labeled with a resident name and the date the inhaler was opened. V8 stated she is unsure who the inhalers belonged to and maybe the midnight nurse put them in the top drawer to figure out whose inhalers they were.On 2/13/2026 at 9:39 AM V2, Director of Nursing, stated she expects all medications including inhalers to be labeled with the resident's name and the date the medication was opened.The Facility's Medication Storage In The Facility Policy dated 12/2016 documents Medications and biologicals are stored safety, securely, and properly following the manufacture or supplier recommendations.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide Ice Cream with meals as ordered for 5 of 5 residents (R6, R24, R74, and R81) reviewed for Nutrition in a sample of 41.Findings include:1.) R1's Face Sheet documents R1 was admitted to the facility on [DATE] and has a medical diagnosis of Dementia and Hypertension.R1's Minimum Data Set (MDS) dated [DATE] documents R1 is moderately cognitively impaired and needs setup or clean-up assistance with eating.R1's Physician Order dated 1/9/2026 at 10:53 AM documents NAS (NO ADDED Salt) diet. Regular texture, THIN LIQUIDS consistency, Super cereal at breakfast with sugar. Vanilla ice cream at Lunch and dinner.R1's Meal Ticket dated 2/6/2026 documents Lunch Daily: VAN Ice Cream. Dinner DAILY: VAN Ice Cream.On 2/5/2026 at 1:00 PM R1 received her lunch tray which consisted of meatloaf, mashed potatoes and gravy, fruit, and cake. R1 did not receive her ice cream as ordered with her lunch tray.On 2/5/2026 at 1:10 PM R1 stated she did not receive her ice cream with her lunch today. R1 stated sometimes she will receive it and sometimes she does not.On 2/6/2026 at 12:30 PM R1 eating lunch tray. No ice cream noted on R1's tray. R1 stated she did not receive her ice cream again today.2.) R6's Undated Face Sheet documents R6 was admitted to the facility on [DATE] and has a medical diagnosis of Gastro-Esophageal Reflux Disease, Schizoaffective Disorder, and Dementia.R6's MDS dated [DATE] documents R6 is severely cognitively impaired and needs supervision or touching assistance with eating.R6's Physician Order dated 6/26/2025 at 2:35 PM documents Regular diet, PUREED texture, THIN LIQUIDS consistency, Divided plate, Super Cereal for breakfast; ice cream for Lunch and dinner.R6's Physician Order dated 10/21/2025 at 1:03 PM documents ice cream at lunch and supper.R6's Meal Ticket dated 2/6/2026 documents Lunch DAILY: Ice Cream. Dinner DAILY: Ice Cream.On 2/6/2026 at 1:51 PM R6 stated she did not receive ice cream with her lunch tray today and does not remember the last time she received ice cream with her meal trays.3.) R24's Undated Face Sheet documents R24 was admitted to the facility on [DATE] and has a diagnosis of Gastro-Esophageal Reflux Disease and Hypertension.R24's MDS dated [DATE] documents R24 is moderately cognitively impaired and needs setup or clean up assistance with eating.R24's Physician Order dated 1/12/2026 at 12:57 PM documents REGULAR diet, MECH/SOFT texture, THIN LIQUIDS consistency, Super cereal with breakfast. Ice cream with Lunch (Strawberry). Fortified pudding with dinner. Double portions at Breakfast & Dinner. Fortified potatoes at Lunch. Offer juice and milk at meals.R24's Meal Ticket dated 2/6/2026 documents Lunch DAILY: Milk Whole. Fortified Potatoes, Ice Cream.On 2/6/2026 at 1:54 PM R24 stated she has not been receiving her ice cream with her lunch for a couple days. R24 stated she will sometimes receive pudding with her tray but has not had her ice cream.4.) R45's Undated Face Sheet document R45 was admitted to the facility on [DATE] and has a medical diagnosis of Type 2 Diabetes Mellitus, Moderate Protein-Calorie Malnutrition, Hypertension, and Gastro-Esophageal Reflux Disease.R45's MDS dated [DATE] documents R45 is cognitively intact and needs setup or clean-up assistance with eating.R45's Physician Order dated 9/2/2025 at 9:14 AM documents LCS (low concentrated sweets) diet, REGULAR texture, REGULAR LIQUIDS consistence, 1 apple juice at breakfast; Ice cream with lunch and Dinner. Double portions all meals.R45's Meal Ticket dated 2/6/2026 documents Lunch DAILY: DOUBLE PORTIONS, Ice Cream. Dinner DAILY: DOUBLE PORTIONS, Ice Cream.On 2/6/2026 at 1:44 PM R45 stated she has not received ice cream with her lunch or dinner tray in a couple days. R45 stated she should not have to ask staff where her ice cream is since it is ordered for her to have it. R45 stated the ice cream was ordered for her to help her with her weight. R45 stated she has not received anything in place of the ice cream on her meal trays.5.) R74's Undated Face Sheet documents R74 was admitted to the facility on [DATE] and has a medical diagnosis of Dysphagia, Protein-Calorie Malnutrition, Hypertension, and Gastro-Esophageal Reflux Disease.R74's MDS dated [DATE] R74 is moderately (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively impaired and needs partial/moderate assistance with eating.R74's Physician Order 11/20/2024 at 10:59 AM documents REGULAR diet, MECH/SOFT texture, THIN LIQUIDS consistency, Put each food item in a bowl. Double portions upon request; ice cream at Lunch.R74's Meal Ticket dated 2/6/2026 documents Lunch DAILY: DOUBLR PORTIONS Upon Request, Ice CreamOn 2/6/2026 at 1:48 PM R74 stated he has not received ice cream on his lunch tray for a few days. R74 stated he does not think he has received anything in place of the ice cream.6.) R81's Undated Face Sheet documents R81 was admitted to the facility on [DATE] and has a medical diagnosis of Type 2 Diabetes Mellitus and Gastro-Esophageal Reflux Disorder.R81's MDS dated [DATE] documents R81is cognitively intact and needs setup or clean-up assistance with eating.R81's Physician Order dated 2/3/2026 at 10:21 AM documents LCS diet, REGULAR texture, REGULAR LIQUID consistency, Double protein at breakfast, lunch and dinner. Whole milk at breakfast, Lunch and dinner. Ice cream at Lunch and dinner.R81's Meal Ticket dated 2/6/2026 documents Lunch DAILY: Milk Whole, DOUBLE PORTIONS, Ice Cream. Dinner DAILY: Milk Whole, DOUBLE PORTIONS, Ice Cream.On 2/6/2026 at 3:18 PM R81 stated it has been over 3 weeks since she has received ice cream with her lunch and dinner trays as ordered.On 2/6/2026 at 3:13 PM V15, Registered Dietitian, stated the facility has not notified her that they do not have ice cream available for residents as ordered. V15 stated she knows sometimes the facility will receive ice cream on the delivery trucks and sometimes they will not. V15 stated she expects the facility to be following the resident's diet as ordered.On 2/5/2026 at 8:14 AM, during the tour of the kitchen no ice cream was observed in the freezer.On 2/10/2026 at 2:30 PM, V16, [NAME] stated they had run out of ice cream. She was not sure when they ran out of ice cream, but they have been out of ice cream for just a few days.On 2/13/2026 at 9:29 AM V2, Director of Nursing, stated she expects staff to follow a resident's diet orders and the resident's physician orders.On 2/13/2026 at 9:51 AM V18, Nurse Practitioner, stated she expects the facility to follow a resident's physician ordered diet.The Facility's Dietary Preferences, Nutritional Requirements, and Portion Management Policy Date Last Reviewed 10/30/2025 documents Purpose: To ensure that all residents receive nourishing, palatable, and well-balanced meals that meet their assessed nutritional needs while honoring individual cultural, religious, and personal food preferences.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to perform infection prevention practices during medication administration, including hand hygiene and cleansing of the glucometer to prevent infections in 5 of 9 residents (R16, R52, R69, R75, R49) reviewed for infection prevention and control in the sample of 41.Findings Include:On 2/5/26 at 8:18 AM, Medication administration was observed with V9 LPN (Licensed Practical Nurse), with R52, V9 donned gloves, completed an accu-check and removed her gloves. V9 did not perform hand hygiene before or after donning and removing the gloves and did not clean the glucometer after use. A On 2/5/26 at 8:38 AM, V9 performed an accu-check on R16 with the glucometer used on R52 that had not been cleaned after use. V9 did not perform hand hygiene before or after glove use and did not clean the glucometer after use. V9 then administered R16 her medications and did not perform hand hygiene. On 2/5/26 at 8:55AM, V9 then into R69's room, administered her medications and did not perform hand hygiene before or after administration. On 2/5/26 at 9:05AM, V9 went into R75's room, touching R75 who was complaining of pain and vomiting. V9 did not perform hand hygiene before or after exiting the room. On 2/5/26 at 9:10AM, V9 went into R49's room, completed an accu-check, did not perform hand hygiene before or after glove removal and did not clean the glucometer before or after use. V9 then began to prepare R49's medication, V9 dropped R49's Lyrica on the floor, picked it up off of the floor and placed it into R49's medication cup and proceeded into R49's room and administered his medications, including the Lyrica that was dropped on the floor. V9 did not perform hand hygiene before or after administering R49's medications. On 2/10/26 at 9:25 AM V4, RN/ICP (Registered Nurse/Infection Control Preventionist), stated during medication administration, the nurse should perform hand hygiene each time the resident is touched, and the glucometers are to be cleaned after each use. V4 stated if the nurse drops a medication on the floor, the medication should be wasted, then they are to perform hand hygiene, retrieve a new pill and then administer the medication. V4 stated the nurse should not pick the pill up off of the floor, place it back in the medication cup and administer the medication. The Blood Glucose Machine Cleaning Policy, with a revision date of 4/4/20, documents the following: Obtain bleach or disinfectant wipes, apply gloves, take a pre-moistened disinfectant wipe and clean the entire surface of glucose monitor, allow product to remain on glucose meter according to manufacturer's recommendations, remove and discard gloves, sanitize hands, repeat process between resident use. The Hand Hygiene Policy, with a review date of 4/2024, documents the following: Proper hand hygiene is necessary for the prevention and the transmission of infectious disease. Hand hygiene is done before and after resident contact, before and after any procedure, before putting on gloves and after removing gloves. The Medication Administration Policy, with a review date of 4/2025, documents the following: Hand hygiene must be performed before and after any invasive procedure (i.e. blood glucose monitoring, injections, etc.).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to implement care plan interventions following resident falls for 1 of 10 (R51) residents investigated for falls in a sample of 41.Findings include:R51's EMR (Electronic Medical Record) undated documents that the resident was admitted to the facility on [DATE].R51's EMR dated 3/27/24 documents a diagnosis of Cerebral Infarction, unspecified.R51's EMR dated 2/28/25 documents a diagnosis of Difficulty in walking, not elsewhere classified.R51's EMR dated 6/17/25 documents a diagnosis of Repeated Falls.R51's MDS (Minimum Data Set) 12/5/25 documents a BIMS (Brief Interview for Mental Status) score of 14 out of 15. The MDS documents that the resident requires supervision or touching assistance for roll left and right. The MDS documents that the resident requires partial/moderate assistance for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer.R51's Care Plan dated 3/6/25 documents FALL: high risk for falls r/t (related to) incontinence, impaired balance, history of fall, psychotropic meds.Interventions:3-12-25 - non-skid strips by bed.3-22-25 - toileting pgm (program).3-6-25 - low bed when arrives.4-10-25 - assist with gripper socks.4-14-25 - non-skid strips by toilet.4-20-25 - keep in high traffic area.5-17-25 - anti roll backs when arrives.5-31-25 - dycem in wheelchair.6-18-25 - gripper socks when up in chair.6-22-25 - grab bars x's 2 assist with positioning and transfers dc'd (discontinued) 11-21-25 changed to half rail on right side.7-13-25 - Keep frequently used items within reach.7-14-25 - clinical evaluation.7-26-25 - leave wheelchair in locked position by bed.8-10-25 - no cloth pads in wheelchair.8-22-25 - wheelchair seat modified.8-25-25 - encourage participation in afternoon activities.8-8-25 - bed against wall.9-3-25 - Brightly colored visual aid on call light.10-5-25 - remind to ask for assist with standing.11-15-25 - brightly colored reminder on wheelchair not to stand without assist.11-15-25 - therapy to eval.11-24-25 - frequent observation and assist to have gripper socks in place.11-27-25 - Staff to remind resident to sit up straight in wheelchair.11-9-25 - Encourage AM diversional Activity, involve in activity of choice.12-11-25 - toileting pgm to be modified.12-30-25 - call before you fall sign by bed.12-31-25 - redirect to hall as needed.1-13-26 - re-educate on wheelchair positioning.1-17-26 - dycem under resident in chair and under pad chair.1-23-26 - during rounds staff to observe for covers to be straight.1-26-26 - given reacher.1-27-26 - therapy to eval for wheelchair saddle cushion.R51's Nurses Notes dated 3/6/25 at 9:33 PM documents Resident was put into his bed this evening. When the CNAs (Certified Nursing Aid) went to check on him, he had his diaper off, knees on the floor with the rest of his body lying on the bed. The CNAs got him off the floor and into his bed, and re-educated him to stay in bed, because it's nighttime. He then began to scoot his feet and legs back to the side of the bed. I retrieved a fall mat and placed it on the side of his bed. Plan of care ongoing.R51's intervention dated 3-12-25 documents non-skid strips by bed.On 2/10/26 at 1:13 PM, observation of R51's room. No non-skid strips noted by R51's bed.R51's Nurses Notes dated 4/10/25 at 4:21 PM documents res (resident) was found sitting on floor mat, no injury/pain noted at this time. Will continue to monitor. VS (Vital signs) WNL (Within Normal Limits).R51's intervention dated 4-14-25 documents non-skid strips by toilet.On 2/10/26 at 1:13 PM, observation of R51's room. No non-skid strips noted by R51's toilet.R51's Nurses Notes dated 7/26/25 at 2:12 PM documents Resident was trying to transfer from his bed to the chair in his room unaided and fell on his buttocks. This nurse along with other staff assisted him to his bed. Resident was assessed, no physical injuries noted. Vital signs checked BP (blood pressure) 126/68 P (pulse) 60.R51's Intervention dated 7-26-25 documents leave wheelchair in locked position by bed.On 2/10/26 at 1:13 PM, observation of R51's room. R51's wheelchair was noted to be across the room from resident's bed.R51's Nurses Notes dated 11/27/25 at 4:10 PM documents At 1555, this nurse observed Resident slide from his w/c (wheelchair) to the floor onto his buttocks. Did not hit his head. Assessment completed. Hand grips are strong and equal bilaterally. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PERRL (Pupils Equal Round Reactive to Light). ROM (Range of Motion) WNL per baseline. Denies any pain or discomfort. VSS (Vital signs Stable). Assisted Resident using gait belt and two assists back to his w/c. Director of Nursing notified.R51's Intervention dated 11-15-25 documents brightly colored reminder on wheelchair not to stand without assist.On 2/10/26 at 1:13 PM, observation of R51's room. No brightly colored reminder noted on R51's wheelchair.R51's Nurses Notes dated 12/30/25 at 4:45 PM documents At 1625, CNA called this nurse to Residents room. Observed Resident sitting on the floor in front of his w/c next to his bed. Resident stated he was being stubborn and tried to transfer himself from his w/c to his bed. He denied hitting his head. Denied pain. Head to toe assessment completed. No apparent injuries. No changes in cognition. Hand Grips strong and equal bilaterally. ROM WNL per baseline. PERRL. Resident w/c was not locked. His call light was within his reach. Had on non-skid shoes. Y (temperature) 97.3HR (heart rate) 59 RR (respirations) 18 BP 129/50 SpO2 (oxygen saturation) 97% on RA (room air). Assisted back to his w/c.R51's Intervention dated 12-30-25 documents call before you fall sign by bed.On 2/10/26 at 1:13 PM, observation of R51's room. No call before you fall sign noted by resident's bed.R51's Nurses Notes dated 1/23/26 at 3:00 AM documents This nurse was notified by cna that resident was on the floor. When asked what happened? Resident stated he was tossing and turning in his sleep when he noticed he was on edge of the bed it was too late so he scooted to floor. VS T 98.6 bp 114/55 R 18 P 66 spo2 96% RA. ROM WNL. No injuries no c/o (compliant of) pain. Resident assisted back into bed via (mechanical lift) with assist of 2. Resident in bed at thus time resting.R51's Intervention dated 1/27/26 documents given reacher.On 2/10/26 at 1:13 PM, observation of R51's room. No reacher noted in resident's room.On 2/13/26 at 9:41 AM, V2, DON (Director of Nursing) stated that care plan interventions should be implemented after the facility determines the appropriate fall intervention for the resident.Facility's Fall Prevention and Management policy dated 10/2018 documents This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All residents' falls shall be reviewed, and the residents' existing plan of care shall be evaluated and modified as needed. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.

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	145655	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Woodriver	393 Edwardsville Road Wood River, IL 62095

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to evaluate and revise a resident's Care Plan with progressive interventions following falls for 3 of 10 residents (R2, R19, and R68) in a sample of 41.Findings Include:1.) R2's Undated Face Sheet documents R2 was admitted to the facility on [DATE] and has a medical diagnosis of reduced mobility, muscle weakness, difficulty in walking, dementia, abnormalities of gait and mobility, and repeated falls. R2's Minimum Data Set (MDS) dated [DATE] documents R2 is severely cognitively impaired, uses a wheelchair, needs substantial/maximal assistance with sitting to standing and chair/bed to chair transfers. R2's Care Plan Date Initiated 3/30/2025 documents Fall: R2 is at high risk for falls related to incontinence, weakness, history of fall, glaucoma, confusion, and use of psychotropic meds. Intervention dated 8/10/2025 documents out to emergency room (er.) Intervention dated 11/13/2025 documents brightly colored reminder on wheelchair to not stand up without assist. R2's Care Plan Date Initiated 5/8/2025 Transferring: R2 has a self care deficit in transferring related to impaired balance, weakness. R2's Quarterly Fall Risk Evaluation Dated 7/22/2025 documents R2 is a high fall risk. R2's Nurses Notes dated 8/10/2025 at 11:33 PM documents patient sent to Local Hospital related to falling in room trying to take himself to the bathroom. Complaining of 10/10 pain, barely able to move around from the pain. Survival flight called for transportation and took patient to hospital. The Facility's Fall Investigation for R2's Fall dated 8/10/2025 contains R2's Face Sheet, Physician Orders, Care Plan, and Minimum Data Set Section O (Special Treatments, Procedures, and Program, Section C (Cognitive Patterns, Section GG (Functional Abilities (Admission), Section GG (Functional Abilities- Discharge). No root cause analysis or intervention noted. R2's Care Plan does not document a progressive intervention for R2's fall on 8/10/2025. 2.) R68's Undated Face Sheet documents R68 was admitted to the facility on [DATE] and has a diagnosis of Unsteadiness of Feet, Cerebral Palsy, Weakness, Abnormalities of Gait and Mobility, and Hypertension. R68's MDS dated [DATE] documents R68 is cognitively intact, uses a walker and wheelchair, needs supervision or touching assistance with sitting to standing, chair/bed to chair transfers, toilet transfers, and walking 50 feet with two turns. R68's Fall Risk Evaluation dated 2/4/2025 documents R68 is a high risk for falls. R68's Care Plan Date Initiated 6/16/2021 documents R68 is at high risk for falls related to balance/gait problems, diagnosis cerebral palsy, arthritis, incontinence, psychoactive drug use, history of falls, history of putting/throwing self on floor, non compliance with helmet and fall interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68's Care Plan Date Initiated 2/17/2022 documents ambulation: R68 has a self care deficit in ambulation related to: weakness, CP & unsteady gait, dorsalgia, arthritis R68's Nurses Notes dated 2/14/2025 at 1:59 PM documents at 0615 Certified Nursing Assistants (CNA's) called this nurse into resident room to show what they observed. Resident was laying on the floor on the right side of her bed with blankets wrapped around her and a stuffed animal under her head. Resident stated she slept on the floor last night because she rolled off the bed around 1AM. Resident denies hitting head and denies any pain or discomfort. Resident was assessed for injury with none observed and assisted to sit in wheelchair with two assist. R68's Care Plan does not document a fall intervention for the fall on 2/14/2025. R68's Nurses Notes dated 2/23/2025 at 11:24 AM documents 400 Hall Nurse heard resident yell for help from resident bathroom. 400 Hall Nurse called this nurse to the room and this nurse observed resident sitting on her bottom on the floor of the bathroom. Resident verbally angry that we were in the bathroom assessing her and not immediately helping her off the floor. Resident stated I was trying to go to the bathroom and I just fell. R68's Care Plan does not document a fall intervention for the fall on 2/23/2025. R68's Nurses Notes dated 2/28/2025 at 11:00 AM documents resident found sitting on knees next to bed stating she fell. Upon nurse entering room she said I'm fine and got up and sat in bed without allowing further evaluation. no signs of discomfort. R68's Care Plan does not document a fall intervention for the fall on 2/28/2025. R68's Nurses Notes dated 2/28/2025 at 11:24 PM documents Resident found sitting on knees next to bed stating she fell, she got up and sat in bed independently and refused any assessment. R68's Nurses Notes dated 5/23/2025 at 10:06 PM documents resident in her room on the floor, refusing to be assessed by staff. Neuro checks initiated to continues to refuse vital signs and any further medical attention. Stated she is not going to the hospital after being educated on the risk and safety of possible injuries, but patient still refused. R68's Care Plan does not document a fall intervention for the fall on 5/23/2025. R68's Nurses Notes dated 10/11/2025 at 2:30 PM documents the resident was outside with activities when she fell forward face-first out of the wheelchair around 1:50 pm. This nurse was on lunch, and the covering nurse assessed and called 911 to send to the Hospital. R68's Care Plan does not document a fall intervention for the fall on 10/11/2025. On 2/6/2025 at 2:10 PM V2, Director of Nursing (DON), stated the facility does not have any fall investigations or interventions for R68's falls on 2/14/2025, 2/23/2025, 2/28/2025, 5/23/2025, and 10/11/2025. On 2/13/2026 at V22, MDS Coordinator, stated after a resident experiences a fall, the facility will investigate the fall, determine a root cause analysis for the fall, and implement an intervention for the fall. V22 stated the resident's care plan is updated with an intervention after each resident fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/2026 at 9:29 AM V2, Director of Nursing, stated she expects the facility to investigate every resident fall, implement a fall intervention and update the resident's care plan with the intervention after every fall. On 2/13/2026 at 9:51 AM V18, Nurse Practitioner, stated she accepts the facility to follow their fall policy and implement interventions for residents to help with falls. 3-R19's POS dated January 2026 documents a diagnosis of Type 2 diabetes mellitus, weakness, unsteadiness on feet, cognitive communication deficit, acute kidney failure, chronic kidney disease stage 3, muscle weakness, heart failure, hypertension, generalized anxiety disorder, depression, anemia, insomnia. R19's MDS dated [DATE] document R19 was severely impaired for cognition for activities of daily living. R19's Progress Notes dated 2/3/2026 at 2:28 PM, Resident was trying to get into the bathroom in her wheelchair and fell to the floor. The resident claimed she landed on her right side and that her ankle hurt. This nurse assessed her and there were no open wounds or bruises. The hall CNA's (certified nursing assistants) aided the resident into the wheelchair. This nurse asked if there was any pain, and she claimed there was pain in her right ankle and right hip. Vital signs were within range. R19's Care Plan with a date initiated of 1/15/2025 documents under Fall: is at risk for falls r/t (related to) frequent falls, impaired safety awareness, impaired balance and gait, incontinence. R19's Care Plan dated 3/17/2025 documents, frequent rounding during the day. (No interventions were documented for R19's fall on 2/3/2026. On 2/7/2026 at 3:30 PM, a green folder with R19's POS, Care Plan and nurse's notes were provided by V2, Director of Nursing (DON). On 2/7/2026 at 3:35 PM, V2, Director of Nursing (DON) stated that was everything they had for R19's fall. R19's folder did not contain any interventions and/or anything addressing her fall other than the progress note for her fall on 2/3/2026. The Facility Fall Log documents R19 had a fall on 2/3/2026, No other falls were documented for R19 for the past six months. On 2/10/2026 at 12:44 PM, V1, Administrator stated policy she expects all fall interventions to be documented in the Resident's Care Plans. (R19's Care Plan was not updated and does not document any interventions for her fall on 2/3/2026. The Facility Comprehensive Care Plan Policy with a review date of 3/2025 documents, The facility must develop a comprehensive person-centered care plan for each resident. The Care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mental and psychosocial needs, the comprehensive care plan is reviewed quarterly, annually, and with any significant change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to change soiled bed linens for a dependent resident in 1 of 2 residents (R10), reviewed for ADL (Activities of Daily Living) care provided for dependent residents in the sample of 41.Findings Include:On 2/5/26 at 10:00 AM, R10 was observed in her room lying on her left side. R10 has contractures noted to the left hand, left wrist, left elbow, and left shoulder. R10 was not able to move her left upper or left lower extremities. R10 is able to move her right arm but isn't able to make significant movements or position herself in the bed. On 2/5/26 at 12:13 PM, R10 was observed in her room in bed on her left side. R10 stated they delivered her lunch tray; she ate but made a mess. R10 had a liquid reddish colored substance, on her pillow and incontinence pad that appeared to be from a red colored drink. Surveyor asked R10 if staff were going to come in and change her bedding and R10 stated they already did, R10 then touched the incontinence pad with her right hand and stated it's wet referring to the red staining. On 2/5/26 at 2:17 PM, R10 was observed in bed on her left side with the red staining to the pillow and incontinence pad still there. R10 stated staff had not been in to change her bedding. R10's Face Sheet, undated, documents R10 has the following diagnoses: Hemiplegia/Hemiparesis following Cerebral Infarction involving the Left Non-Dominant Side, Muscle Weakness, and Age-Related Physical Debility.R10's MDS (Minimum Data Set), dated 1/12/26, documents the following: R10 has a BIMS (Brief Interview of Mental Status) score of 6, indicating R10 has severe cognitive impairment, she has limited ROM (Range of Motion) on the bilateral upper and lower extremities, and is dependent with hygiene. R10's Care Plan, dated 12/10/25, documents R10 has an ADL self-care deficit and requires assistance from staff.On 2/6/26 at 9:00 AM, V14, R10's Family, stated that she was very concerned about R10's care and she is wanting to pay for R10 to be sent to a facility closer to her so she can monitor her care. V14 stated she has to be an advocate for R10 because she isn't getting cared for. On 2/10/26 at 2:12 PM V2, DON (Director of Nurses), stated ADL care, including bedding changes, are provided every day and as needed. The Activities of Daily Living for Dependent Residents Policy, with a review date of 8/2024, documents it is a program of activities of daily living provided to prevent disability or to maintain residents at their maximal level of functioning based on their diagnosis.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to implement pressure relieving interventions for the prevention and treatment of pressure ulcers in 1 of 2 residents (R10) reviewed for treatment/services to prevent/heal pressure ulcers in the sample of 41.Findings Include:On 2/5/26 at 10:00 AM, R10 was observed in her room lying on her left side, a heel protector to the left foot, no pillow between her knees or under her heels and is very thin in appearance. R10 has contractures noted to the left hand, left wrist, left elbow, and left shoulder. R10 was not able to move her left upper or left lower extremities. R10 is able to move her right arm but isn't able to make significant movements or position herself in the bed. R10 stated she has several wounds that she had prior to admission to the facility. On 2/10/26 at 7:53 AM, R10 was observed in bed, on her back/left side, knees contracted up to her waist, nothing between her knees, ankles, nothing under her heels, the left ankle was touching the bed, and R10's pressure relieving boot was on the bed but was not on. R10 was complaining of pain and was anxious, surveyor told her that she would notify the nurse and R10 stated they haven't done anything for her.On 2/10/26 at 9:25 AM, R10 was observed in bed in the same position as the observation on 2/10/26 at 7:53 AM with no pressure relieving items/interventions in place. R10 stated she has not been repositioned.On 2/10/26 at 10:36 AM, R10 remained in the same position/conditions as she did on 2/10/26 at the 9:25 AM observation and R10 stated the staff hasn't done anything for her. R10's Face Sheet, undated, documents R10 has the following diagnoses: Hemiplegia/Hemiparesis following Cerebral Infarction involving the Left Non-Dominant Side, Moderate Protein-Calorie Malnutrition, Muscle Weakness, Age Related Physical Debility, Soft Tissue Disorders, and Skin Transplant Status.R10's MDS (Minimum Data Set), dated 1/12/26, documents the following: R10 has a BIMS (Brief Interview of Mental Status) score of 6, indicating R10 has severe cognitive impairment, she has limited ROM (Range of Motion) on the bilateral upper and lower extremities; is dependent with rolling in bed, has one stage two pressure ulcer not present upon admission, one stage three pressure ulcer present upon admission, and two DTI's (Deep Tissue Injuries) not present upon admission, and is not on a turning/repositioning program.R10's Care Plan, dated 12/10/25, documents R10 has an ADL (Activities of Daily Living) self-care deficit and requires staff assistance with ADLs, and has pressure ulcers to the left ankle (stage 3), left medial lower leg (stage 3), left great toe (DTI), and left 4th toe (DTI). R10 has an intervention to assist and encourage resident to turn and reposition frequently. R10's Progress Note, dated 12/10/25 at 3:53 PM, documents the following: Resident admitted to facility with osteomyelitis of the LLE (Left Lower Extremity), wounds to both medial and lateral ankle. Wound nurse notified of areas on skin. Resident is alert and oriented times 3-4 with moments of confusion. Left sided paralysis noted from past CVA (Cerebral Vascular Accident). Resident is incontinent of bowel and bladder. Transfers full mechanical lift and is a full code.R10's Progress Note, dated 12/24/25 at 1:03 PM, documents the following: Resident seen by the Wound NP (Nurse Practitioner) today. No new orders. Wound to left anterior ankle noted to be improving with a well-defined wound margin. No tunneling or undermining noted. Wound to resident's left medial lower leg noted to be improving with a flat and intact wound margin. No tunneling or undermining present. Resident tolerated treatments well.R10's Progress Note, dated 12/31/25 at 1:57 PM, documents the following: Resident seen by Wound NP. No new orders received. Wounds to left ankle and left medial leg noted to be improving.R10's Progress Note, dated 1/8/26 at 7:31 PM, documents the following: Resident seen by Wound NP. New areas noted during wound care. New area noted to the left fourth toe and left inner knee. New orders for the left great toe for area to be cleansed with wound cleanser and pat dry, skin prep applied daily and as needed. New orders for the left inner knee for area to be cleansed with wound cleanser, pat dry and cover with a bordered gauze. The area to the left medial leg is resolved. The wound to left anterior ankle noted to be improving with 40% epithelialization and 60% hyper granulation with measurements of: Length 2cm (centimeters); Width 2cm. Wound to left great toe (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted to be a DTI with non-blanchable deep red area with measurements of: Length 7cm; Width 4cm. Wound to left fourth toe noted to be a DTI with non-blanchable deep red. Wound to left knee noted to be a stage 2 pressure injury with well-defined wound margin with measurements of: Length 3cm; width 1cm; Depth 0.1cm. Area noted with 20% epithelialization and 80% granulation.R10's Progress date, dated 1/15/2026 at 7:21 AM, documents the following: Resident seen by Wound NP. Wounds noted to be improving. The left ankle measuring 2cm x 1.5cm x 0.2cm. New orders for left ankle to be cleansed with wound cleanser, pat dry, apply honey gel and cover with a dry dressing. The left inner knee measuring 1.5cm x 2.5cm. New orders for wound to be cleansed with wound cleanser, pat dry, apply hydrogel to the wound bed and cover with a dry dressing. The left great toe area is improving, apply povidone iodine and leave open to air.R10's Progress note, dated 2/6/26 at 11:46 AM, documents the following: Care plan meeting held with R10's family and they are wanting to move her closer to them. Social Service Director will help with that when the decision is made. On 2/6/26 at 9:00 AM, V14, R10's Family, stated that she was very concerned about R10's care. V14 stated when R10 was admitted to the facility, she had several wounds because of her past stroke, but she doesn't think she is getting the care for her wounds or in general here. R10 stated she is wanting to pay for R10 to be sent to a facility closer to her so she can monitor her care. V14 stated she has to be an advocate for R10 because she isn't getting cared for. On 2/10/26 at 10:36 AM V5, Wound Nurse, stated R10 has a pressure injury to the left outer ankle, she also had one to the left medial leg, but it has resolved. V5 stated R10 was admitted to the facility with the pressure ulcer to the left outer ankle. V5 stated R10 should have her feet elevated and is to be T&R (Turned and Repositioned) as tolerated. On 2/10/26 at 2:12 PM V2, DON (Director or Nurses), stated they turn and reposition the residents for pressure relief every 2 hours. The Pressure Injuries Policy, with a review date of 9/2025, documents the following: The purpose of this policy is to prevent or reduce the incidence of pressure injuries, standards of practice should be implemented. A pressure injury may be defined as any lesions caused by unrelieved pressure that results in damage to the underlying tissue.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility to ensure staff were observing residents taking their medications and no medication was given to residents without supervision for 1 of 29 residents (R67) (reviewed for medications in the sample of 41. Findings include: R66's Physician Order Sheets (POS), document R66 has a diagnosis of Chronic Kidney Disease, Stage 4 (severe) and Hypokalemia and has an order for Potassium Chloride ER (extended release) Tablet Extended Release 10 MEQ (Milliequivalent). R66's Minimum Data Sets (MDS) dated [DATE] documents she is cognitively intact for decision making of activities of daily living. R66's Care Plan dated 3/9/2022 documents, meds as ordered. On 2/5/2026 at 8:39 AM, R66's table had a small clear cup of water sitting on it and next to it were two large pills left unattended. On 2/5/2026 at 8:39 AM, R66 was asked if she knew what those pills were, and she stated yes, they were her potassium chloride medications to help her with her potassium levels. The nurse had left them for her, and she planned on taking them later.The Facility Medication Administration Policy with a review date of 4/2025 documents, All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. Explain procedure to resident and give the medication, remain with the resident to ensure that the resident swallows the medication.