STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0057489**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF WOODRIVER	**393 EDWARDSVILLE ROAD , WOOD RIVER, Illinois, 62095**

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S0000	Initial Comments Complaint Investigations 25410763/2660163 25410903/2662925	S0000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1030a)1) 300.1030c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). c) At least one staff person shall be on duty at all times who has been properly trained to handle the medical emergencies in subsection (a). This staff person may also be counted in fulfilling the requirement of subsection (d) if the staff person meets the specified certification requirements. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to provide necessary emergent care and services for 1 of 1 resident (R2) with a tracheostomy in the sample of 1. This failure resulted in R2 being sent out urgently via EMS (Emergency Medical Services) for trach reinsertion after staff failed to attempt to reinsert R2's trach when it was found dislodged. R2 was admitted to the ICU (Intensive Care Unit) for respiratory distress. This has the potential to affect current and new admissions that require tracheostomy care. Findings include: R2's Undated Face Sheet, documents he was initially admitted to the facility on 10/30/2025 with diagnoses including acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), trach, gastrostomy (G-Tube), supraventricular tachycardia (SVT), anemia, atrial fibrillation (A-Fib), pneumonia, sepsis, weakness, bilateral paralysis of vocal cords and larynx, hypoxemia, left ventricular failure, aneurysm of the ascending aorta without rupture, saddle embolus of pulmonary artery and congestive heart failure. R2's NRSG (Nursing) Admission Assessment, dated 10/30/2025 documents reason for admission: rehabilitation. Other related illnesses and/or previous hospitalizations: acute respiratory failure, saddle PE, pneumonia, hypertension, high cholesterol, VT, A-Fib. Respiratory: regular unlabored, Oxygen humification at 28%. Lung sounds: clear and diminished, resident has a trach which is size 6.	S9999		

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S9999	Continued from page 2 The Facility's Staffing Pattern dated 11/1/2025 documents 2 agency LPNs (Licensed Practical Nurses) on night shift. R2's Late Entry Nurse's Note, dated 11/2/2025 at 2:30 AM V18, LPN (Licensed Practical Nurse) documents an unwitnessed fall for R2. R2 was found lying on the floor on the right side of his bed within reach of call light. R2 stated he was trying to get up. R2 was immediately assessed by this nurse. R2 was alert and oriented 2-3, denied any loss of consciousness but confirm his head hit the floor, vital was (sic) stable. Upon getting R2 back in bed, I noticed a small laceration to the right side of the forehead above the eyebrow and that trach was out. R2 complained of no pain or trouble breathing. No RN (Registered Nurse) was on duty, so R2 was sent out to the emergency room. R2 was vital was monitored until EMS (Emergency Medical Services) arrived. On call staffing was also notified. No documentation staff attempted to reinsert R2's trach or what his vital signs including oxygen saturation was at that time. On 11/12/2025 at 1:25 PM V18, LPN stated she was an agency nurse and was assigned to R2 on night shift on 11/1/2025 into 1/2/2025. V18 stated she got to the facility around 10:00 PM and did rounds at that time. V18 stated R2 was lying in bed and was resting. V18 stated R2 had a trach and it was in and connected to oxygen when she did the initial rounds that shift. V18 stated V11, CNA (Certified Nurse Assistant) reported to her that R2 fell out of bed at approximately 2:30 AM and she went and assessed him immediately. V18 stated during the assessment of R2 he was lying on the right side of his bed on the floor and his trach was out. V18 stated she assessed R2's head had a laceration at that time, and she used nursing judgement and called EMS to transport R2 to the local emergency room (ER.) V18 stated she assessed R2's oxygen and while he laid on the floor and it was low 90's and then staff transferred R2 back to bed and she placed oxygen via an oxygen mask, and his oxygen went to 95%-96%. V18 stated R2 didn't experience respiratory distress and EMS transported him to the ER. V18 stated she didn't attempt to reinsert R2's trach at that time because she wasn't in-serviced on how to do that and she didn't feel comfortable or confident in attempting to reinsert a trach. V18 stated it was night shift and there was no RN in the building, and she felt R2 needed to be assessed by a physician. V18 stated there was only one other LPN working and she asked her if she knew how to reinsert a trach and she told her it isn't in the LPN nurse's scope of practice to reinsert trachs. V18	S9999		

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S9999	Continued from page 3 stated she didn't know what size R2's trach was or that trachs come in different sizes and she didn't know where to find that information. V18 stated she didn't know if there was a back up trach emergency kit in R2's room and didn't know where to locate a backup trach either. On 11/12/2025 at 3:50 PM V19, LPN stated she was an agency nurse and worked night shift on 11/1/2025 into 11/2/2025. V19 stated she wasn't assigned to R2 and she didn't assist or assess R2 at anytime that shift. V19 stated after V18 called EMS and R2 was transferred to the ER V18 asked her if she should have reinserted R2's trach and V19 told her that that's not in the LPN nurse's scope of practice and so she shouldn't do it. V19 stated at no time did V18 ask her to assist her to take care or assess R2 and she wouldn't have attempted to reinsert R2's trach after it was dislodged because she wasn't in-serviced on trach reinsertion prior to working at the facility and she didn't feel comfortable or confident in even attempting to reinsert a trach. V19 stated she's never been assigned to a resident with a trach, so she doesn't know where the trach size is documented, or what supplies are needed to care for a trach. On 11/6/2025 at 10:45 AM V15, stated she is R2's POA (Power of Attorney) stated R2's trach fell out when he fell out of bed in the middle of the night on 11/2/2025 and he was transferred to the local emergency room. That hospital told her they didn't have proper staff to reinsert the trach so he had to be transferred to a larger hospital out of state. That hospital reinserted his trach and he was admitted to the intensive care unit (ICU) for respiratory distress and he is still in the ICU. R2's Hospital Emergency Department (ED) Paperwork, dated 11/2/2025 documents principle problem: acute respiratory failure with hypoxia and hypercapnia. Pt (patient) presents to the ED via EMS. Patient is supposed to have a trach in place that is not present. Physical exam: trach site with no patency, unable to replace trach, decreased breath sounds bilaterally with shallow respirations, tachypneic. Clinical notes: will attempt to replace trach and evaluate for airway compromise. Diagnosis: trach complication. Disposition: transfer to larger hospital. General comments: Patient had trach placed for vocal cord paralysis. We were unable to replace trach here. Patient discussed with a larger hospital ENT (Ear, Nose Throat Specialist) and they will replace trach there. On 11/14/2025 at 8:56 AM V2, DON/AIT stated all nurses	S9999		

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S9999	Continued from page 4 including agency nurses were in-serviced on emergency trach reinsertion in October 2025 and then again in November 2025. V2 stated to her knowledge all nurses, including agency nurses have been in-serviced on emergency trach reinsertion prior to working at the facility and no agency nurses have voiced that they don't feel confident or comfortable with reinserting a trach in an emergent situation. V2 stated when a resident's trach is dislodged for any reason she expects the nurse to reinsert the trach and document the trach reinsertion attempts in the resident's medical record and if the nurse is unsuccessful in trach reinsertion she expects the nurse to call for EMS to assist and if they can't reinsert the trach and stabilize the resident she expects EMS to transport the resident to the emergency room. V2 stated when a trach is dislodged the resident airway is compromised and the resident could experience respiratory distress and could cause respiratory failure and could lead to death. V2 stated she didn't know if reinserting a trach is within an LPNs scope of practice and that she'd have to look that up. On 11/13/2025 at 11:05 AM V20, Nurse Practitioner (NP) stated she assessed R2 on 10/31/2025. He had a trach and it was clear and staff were providing trach care per physician's orders. V20 stated she expected nurses including agency nurses to be in-serviced/educated on emergent trach care including trach reinsertion because when a resident has a trach it is considered medically necessary for breathing and when a trach is dislodged for any reason it should be reinserted immediately because without it could lead the resident to having respiratory distress which could lead to brain death. V20 stated when she assessed R2 on 10/31/2025 she couldn't recall if there was an emergency trach reinsert kit in his room, but she expected there to be one in R2's room in case of dislodgement. V20 stated she expected staff to document resident's trach size in the resident's medical record so nurses would know what size to reinsert if the trach is dislodged. On 11/14/2025 at 12:25 PM V3, ADON stated the facility's trach care policy doesn't document instructions on how to reinsert a trach if it is dislodged and they have been in-servicing nurses using a trach care skills checklist this week, but it also didn't include trach insertion instructions. V3 clarified the facility doesn't have a policy or skill checklist that covers trach reinsertion, so no staff have been in-serviced on trach reinsertion. V3 stated the facility is currently working on finding a trach skills checklist for trach reinsertion so they can in-service nurses on it.	S9999		

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S9999	Continued from page 5 The Facility's "Tracheostomy Care Policy" revised 10/2024 documents, it is the policy of this facility that residents with tracheostomies receive routine care to maintain a patent airway. No documentation regarding trach reinsertion is addressed in the facility policy. The Facility's "Facility Assessment" dated 6/18/2025 documents the Facility provides care for COPD, pneumonia, asthma, chronic lung disease, and respiratory failure. Specialized Rehabilitation Services include Respiratory. Special Care Needs include tracheostomy care and ventilator care. (A)	S9999		