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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42636 Based on observation, interview and record review, the facility allowed its staff to use cell phones in the resident areas, resulting in an un-homelike environment for 5 of 5 residents (R1, R2, R3, R4, and R5) reviewed for resident rights in the sample of 9. Findings include: On 1/24/25 at 9:35 AM V6, LPN (Licensed Practical Nurse) was observed at the nurse's station on her cell phone. On 1/24/25 at 9:40 AM V5, LPN, was observed at the nurse's station on her cell phone. On 1/24/25 at 2:42 PM V7, Agency RN (Registered Nurse), was observed on his cell phone at the 400/500 nurse's station. On 1/28/25 at 11:07 AM V12, CNA (Certified Nursing Assistant) was observed leaning on the nurse's desk between 100/200 hall on his cell phone. On 1/28/25 at 11:27 AM V12, CNA, was observed sitting on a bench by the dining room on her cell phone. On 1/29/25 at 4:10 AM, V18, CNA, was observed on the 200 hallway, lying in a reclining wheelchair, covered up, on her cell phone. On 1/24/25 at 9:30 AM, R3 stated the staff are always on their cell phones when they should be taking care of them. On 1/24/25 at 9:45 AM, R2 stated the CNAs are on their cell phones all the time and that is one of the reasons they don't help when you need it. On 1/24/25 at 9:50 AM, R4 stated staff are always on their cell phones and she does not like that. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/25 at 12:50 PM, R1 stated that staff are always on their cell phones, and they will stand outside the rooms and play games on their phones. R4 stated staff will be playing on their phones and won't answer the call lights until they are done playing their games or whatever they are doing. R4 stated when staff are on their cell phone it makes her feel neglected. On 1/28/25 at 3:20 PM, R5 stated staff are always on their cell phones. On 1/29/25 at 6:45 AM, V1 (Administrator) stated staff should not be on their cell phones for personal use or talking on their cell phones during work time. The Resident Council Minutes, dated 11/21/24, documents the CNAs stay on their cell phones and don't come down when it is time to feed the residents. The Cellular Phone and Electronic Tablet Policy, dated 1/1/24, documents employees are not permitted to have personal cellular phones, or electronic tablets during work time. The Resident Rights Policy, dated 8/1/22, documents the objective of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preferences.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42636

Based on observation, interview, and record review, the facility failed to provide showers and incontinent care to 3 of 5 residents (R1, R2, and R5) reviewed for care provided to dependent residents in the sample of 9.

Findings include:

1. On 1/24/25 at 12:50 PM, R1 was observed and stated she does not receive showers because she has a port in her chest and staff does not want to get it wet and they will not cover it. R4 stated she occasionally gets a bed bath but not often and she thinks her last bed bath was last week. R4 stated that staff rarely washes her hair.

On 1/29/25 at 4:18 AM, R1 was observed in bed lying on her left side, with a slight feces' odor noted. R1 stated she thinks she pooped. R1 stated she hasn't been changed since she was put to bed last night (1/28/25), unsure of time. R1 stated they won't change her until they get her up around 5:00 AM.

On 1/29/25 at 4:50 AM, R1 was observed with V21, CNA (Certified Nursing Assistant), in bed. V21 stated R1 uses her call light and will tell her when she needs changed. R1 stated she can't feel down there so she doesn't know when she's pooped. R1 was in an incontinent brief, the brief was pulled back with a streak of feces noted in the brief. V21 stated it's just a streak, like she pooped a little when she passed gas. V21 then pulled residents brief back up, closed it and stated she would be getting her up for the day in a little while and left the room without providing incontinent care.

R1's Face Sheet, undated, documents R1 has a diagnosis of Weakness.

R1's MDS (Minimum Data Set, dated dated [DATE], documents R1 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R1 is cognitively intact, needs substantial/maximal assistance with toileting, bathing/showering, and rolling in bed and is always incontinent of bowel and bladder.

R1's Care Plan, dated 1/10/25, documents R1 requires assistance with daily care needs.

R1's Shower Record and Shower Sheets, document R1 received showers on 12/30/24 and 1/21/25, with no documentation indicating R1 received a shower between 12/30/24 and 1/21/25.

2. On 1/24/25 at 9:45 AM, R2 stated she got a shower yesterday for the first time in 2 weeks, she's been in the facility 3 weeks and only had a shower twice.

R2's MDS, dated [DATE], documents R2 has a BIMS of 14 indicating R2 is cognitively intact and is dependent with showers.

R2's Care Plan, dated 12/11/24, documents R2 requires assistance with daily care needs.

R2's Shower Record and Shower Sheets, document R2 received a shower on 1/2/25 and 1/15/25, with no documentation indicating R2 received a shower between 1/2/25 and 1/15/25.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 1/28/25 at 3:20 PM, R5 stated he only gets a shower when they will give him one, which isn't very often. R5's MDS, dated [DATE], documents R5 has a BIMS of 15 indicating R5 is cognitively intact and requires substantial/maximal assist with baths/showers. R5's Care Plan, dated 2/1/24, documents R5 requires assistance with daily care needs. R5's Shower Record and Shower Sheets, document R5 received a shower on 1/3/25 and 1/24/25, with no documentation indicating R5 had a received a shower between 1/3/25 and 1/24/25. R5's Grievance, dated 1/20/25, documents the facility was notified by the facility owner that R5's family sent an email voicing concerns regarding R5's nursing care and dietary concerns. The DON (Director of Nurses) contacted the family on 1/20/25. There are no summary or findings documented on the form. On 1/29/25 at 6:45 AM, V1, Administrator, stated the residents should be receiving a shower twice a week. The Resident Council Minutes, dated 12/19/24, document the CNAs are not changing the residents or giving them showers. The Activities of Daily Living Policy, dated 6/2015, documents showers or baths are scheduled and assistance is provided when required and elimination assistance is given as required.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review the facility failed to administer a seizure medication for 1 of 8 residents (R7) reviewed for significant medication errors in the sample of 9. This failure resulted in R7 having multiple seizures, requiring hospitalization . Findings include: On 1/28/25 at 1:20 PM, R7 stated she didn't get her seizure medication for two days, had four seizures and was admitted to the hospital. R7 stated this happens often but she has and is getting her medication now. R7's Face Sheet, undated, documents R1 has a diagnosis of Epilepsy. R7's MDS (Minimum Data Set), dated 12/2/24, documents R1 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact. R7's Care Plan, dated 9/23/19, documents R7 requires healthcare monitoring related to a diagnosis of a seizure disorder. She is at risk for injury due to uncontrolled seizure activity. She is at risk for aspiration of respiratory secretions or vomiting during seizure and suffocation. She receives antispasmodic medication per physician orders. Intervention is to administer medications as ordered. R7's POS (Physicians Order Sheet) documents the following orders: 6/8/23 - Vimpat Oral Tablet 50 MG (Milligrams), Give 1 tablet by mouth two times a day for Epilepsy, Give with 200 mg to equal 250 mg two times a day. 7/19/22 - Vimpat Tablet 200 MG, Give 1 tablet by mouth two times a day related to Epilepsy. R7's Progress Notes, document the following: -11/18/2024 at 11:26 AM - This writer made aware that res stated she just had small seizure in room while sitting in wheelchair. Stated it only lasted a few seconds, no falls or injuries. Vitals 105/58, 69, 97.6, 98%. NP (Nurse Practitioner), admin (Administrator), and DON made aware. Resident also stated that she had a fall last night, assessed that left middle finger is swollen. Pain level 6 PRN (as needed) Norco given. Will continue to monitor. -1/1/2025 at 3:45 PM - Patient was noted to have seizure activity for 30 seconds, in her wheelchair, patient came out of the seizure. Patient v/s (vital signs) was taken 122/80, 81, 98.2, 18, 98%. Patient took all her meds after the episode, resident family, DON made aware, MD was made aware of the incident. Res Keppra (seizure medication) level reordered for tomorrow. Resident in a pleasant mood and cooperative to cares. -1/20/2025 10:45 PM - Medication Administration Note - Vimpat Oral Tablet 50 MG, Give 1 tablet by mouth two times a day for Epilepsy Give with 200 mg to equal 250 mg two times a day, Need a script. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-1/20/2025 at 6:16 PM - Resident noted to have a seizure lasting approximately 1 minute NP made aware new order for labs resident and family aware. -1/21/2025 7:36 PM - This resident had a 2 minute witnessed seizure, resident was seizing in her chair and was sliding downward this nurse caught her in time and let her seizure take its course before assisting her correctly in her seat. This resident was a bit lethargic and confused once coming out of seizure after a few minutes this nurse asked her name, birthday, and place and she answered correctly. BP 142/69, P 63, R 18, T 97.9. This res was out of Vimpat, there wasn't any in the Cubic to pull from. Script was sent over around noon and when this nurse called for an update the pharmacy stated they never received it. This nurse resent the script and they stated it would be sent out tonight and that they are unable to send it to our backup pharmacy because they would want a separate script. (On-call MD) notified, POA (Power of Attorney) called n/a (not available) at this time, & DON notified. The doctor on call was also made aware that pharmacy was called and stated that meds will be sent out tonight she stated to monitor this resident until her medications arrive. Resident is now in her bed watching TV (television) at this time. Call light is in place. -1/21/2025 8:20 PM - This nurse called and spoke with (on call MD) about sending a stat script for this resident's Vimpat, she stated it has been sent over to our backup pharmacy and it should cover tonight's and tomorrow morning med pass. DON and Admin notified. -1/21/2025 at 10:46 PM - Medication Administration Note, Vimpat Tablet 200 MG, Give 1 tablet by mouth two times a day related to Epilepsy, Medication not available. -1/22/2025 6:03 PM - This resident had a seizure that lasted 59 seconds while lying down in her bed. Resident stating, she didn't feel well and said she felt like she was going to seize, this nurse stated to her that it is best she lie down instead of sitting in chair, so she does not fall, and she agreed, moments later resident started seizing and this nurse was a witness and turned her to her side and counted it to 59 seconds. Res VS are: b/p 120/64, P 63, T 97.3, O2 97, R 20, PAIN 0. Pupils are equal and reactive, POA has been notified and stated to this nurse Thanks and that she appreciates the call. DON & ADMIN notified, & (on call MD) notified to just keep an eye out on res throughout the night. There are NNO (No new orders) at this time. -1/22/2025 9:10 PM - This resident started having seizures back to back, M.D. stated to send this resident out. Resident has been sent to the hospital for observation. POA, Admin and DON notified. -1/23/2025 6:29 AM - Resident admitted to the hospital, room [ROOM NUMBER] with a Dx (diagnosis) of Seizures. -1/24/2025 at 2:35 PM - Resident arrived back at facility in wheelchair, assisted by 2 (facility) employees with NNO. R7's Medication Administration Record (MAR), dated 1/20/25, documents R7's Vimpat was not given as ordered on 1/19/25, 1/20/25, and 1/21/25. R7's Hospital Records, dated 1/22/25, R7 was admitted to the hospital with a diagnosis of Seizures. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 1/28/25 at 11:05 AM, V11, Family Nurse Practitioner, stated R7 not being given the Vimpat on 1/19/25, 1/20/25, 1/21/25, and 1/22/25, did contribute to R7 having seizures and subsequently being admitted to the hospital. V11 stated that medications are a big issue at this facility, there is no initiative from the nurses to make sure residents have prescriptions for their medications. V11 stated it is left on the DON (Director of Nurses) and ADON (Assistant Director of Nurses) to ensure this is happening. V11 stated he will check with the DON/ADON to see if any prescriptions are needed, if so, he will take care of it, give it to the DON/ADON to send to the pharmacy. V11 stated it's also a pharmacy issue because once they have sent a copy of the prescription to them and have confirmation that it was received, the facility still has to call them to get confirmation that they received it and find out when the medication is going to be arriving at the facility. V11 stated a lot of times, pharmacy will say that they didn't receive the prescription even though the facility has fax confirmation that it was sent. On 1/28/25 at 1:23 PM, V16, LPN (Licensed Practical Nurse), stated she sent R7 to the hospital for seizures. V16 stated R7 went for a couple of days without her Vimpat (seizure medication), and she can't go without it for one day and she has seizures. V16 stated normally they could get the medication from the emergency kit, but the Vimpat was not available. V16 stated pharmacy wouldn't send it and told the facility that they didn't receive the prescription for it, so they sent it again and finally received it. On 1/29/25 at 6:45 AM, V1, Administrator, stated they were unable to get R7's Vimpat due to the insurance not paying for the medication until 1/24/25, so when the DON was notified, unsure of the date, that R7 was out of the medication and pharmacy would not send it until 1/24/25, the medication order was sent to the local pharmacy and the facility paid for it and picked it up on 1/22/25. The Medication Administration Policy, dated 6/2015, documents if a medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider if required. If a medication is ordered but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available, obtain from the contingency or convenience box. If the Physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's medical record.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42636 Based on observation, interview, and record review, the facility failed to provide palatable food at an acceptable temperature for 4 of 5 residents (R1, R2, R3, and R5) reviewed for food provided at a preferred temperature in the sample of 9. Findings include: 1. On 1/28/25 at 8:43 AM, hall tray temperatures were taken with the following noted: on the 100 hall the potatoes temped at 105 degrees Fahrenheit, and the grits temped at 141 degrees Fahrenheit. On the 500 hall, the 500 hall tray potatoes temped at 120.7 degrees Fahrenheit, and the eggs temped at 92.6 degrees Fahrenheit. On 1/29/25 at 4:18 AM, R1 stated the food is always cold when she gets it in her room. 2. On 1/24/25 at 9:45 AM, R2 was observed in her room with her breakfast tray on her bedside table untouched. R2 stated the food is terrible, that is why she didn't eat it this morning. R2 stated, sometimes you can get a cheeseburger but it's cold like the rest of the food and if she gets a grilled cheese, it's cold and burnt. 3. On 1/24/25 at 9:30 AM, R3 stated the food is the worst on earth, cold, unidentifiable, strange, it tastes terrible and is always cold. R3 stated she isn't sure if she can get an alternate or substitution at meals because no one has ever offered. 4. On 1/28/25 at 3:20 PM, R5 stated the food is cold and tastes bad. R5's Grievance, dated 1/20/25, documents the facility was notified by the facility owner that R5's family sent an email voicing concerns regarding dietary concerns. The DON (Director of Nurses) contacted the family on 1/20/25. There are no summary or findings documented on the form. On 1/28/25 at 12:00 PM, V13, Dietary Manager, stated the food temperatures are checked before the meal goes out to the steam table and then again at the end of the meal. V13 stated the hall tray food temperatures are checked occasionally, about once a week. V13 stated the food committee had complained recently about the eggs being cold on the hall trays. V13 stated she has been at the facility for 6 weeks now and when she first came, she was told that the plate warmer was broken, she checked it and is working so they have recently been using it. V13 stated when the tray goes out onto the hall it has a plate cover on it. V13 stated they have a pellet warmer that they can use on the bottom of the plate, but if the plate is cold, it will crack it, so they weren't using it but are going to start using it for the hall trays. On 1/29/25 at 6:45 AM, V1, Administrator, stated she was not aware that the plate warmer in the kitchen was broken until recently and she inquired with the dietary staff as to why they couldn't use the other plate warming (Pellet) system and was told that if a cold plate was placed in that system, it would break the plate so they were placing the plates on the steam table during serving times to try and warm the plates. V1 stated the plate warmer is now fixed and dietary staff should be using both plate warming systems. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Council Minutes, dated 12/19/25, document the food is cold and the breakfast needs to improve. The Food Preparation Policy, dated 5/2014, documents all foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit for hot holding, or as state regulation requires.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 42636 Based on observation, interview, and record review, the facility failed to provide nourishing snacks between meals or at bedtime for 4 of 5 residents (R1, R2, R3, and R5) reviewed for snacks in the sample of 9. Findings include: 1. On 1/29/25 at 4:20 AM, V19, LPN (Licensed Practical Nurse) stated they always have snacks available for the residents. V19 stated they were passed out to the residents last night around 8:00 PM, pointing to 2 trays on the shelf at the nurse's station, and stated this is what's left. There were bags of marshmallows and an applesauce left on the trays. V19 stated the residents get what they want off of the tray and leave what they don't. V19 stated there are usually marshmallows, fudge rounds and applesauce available. On 1/28/25 at 8:35 AM, the breakfast trays were taken to the 100 hall to be passed out by staff. On 1/28/25 at 11:17 AM, R1 stated if the facility brings snacks, they are usually left at the nurse's station. R1 stated the facility still did not offer snacks and if it wasn't for her roommate who is able to go to the nurse's station and get them then she would not get one. R1 stated there are a few residents that will take all the snacks from the nurse's station and there are none for everyone else. R1's Face Sheet, undated, documents R1 has the following Diagnoses: Diabetes, End Stage Renal Disease and Dependence on Renal Dialysis 2. On 1/24/25 at 9:45 AM, R2 stated she is diabetic and never gets snacks. R2's Face Sheet, undated, documents R2 has a diagnosis of Diabetes. 3. On 1/24/25 at 9:30 AM, R3 stated she never gets snacks. R3's Face Sheet, undated, documents R3 has a diagnosis of Chronic Kidney Disease and Dependence on Renal Dialysis. 4. On 1/28/25 at 3:20 PM, R5 stated he doesn't ever get snacks at night because everyone else has already eaten them and there isn't any left for him. R5 stated he has lost a lot of weight because he isn't getting his meals or snacks, sometimes he will go all day with nothing to eat until supper and has to demand something because he starts feeling bad. R5's Face Sheet, undated, documents R5 has the following diagnoses: Protein-Calorie Malnutrition, End Stage Renal Disease, and Dependence on Renal Dialysis. (continued on next page)

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Grievance, dated 1/20/25, documents the facility was notified by the facility owner that R5's family sent an email voicing concerns regarding dietary concerns. The DON (Director of Nurses) contacted the family on 1/20/25. There are no summary or findings documented on the form. On 1/28/25 at 12:00 PM, V13, Dietary Manager, stated snacks are taken out by the dietary staff to the nurse's station around 7:30 PM - 8:00 PM and then staff on the hallway are to pass them out. V13 stated the food committee recently complained that the snacks don't get passed/offered by the staff, instead the alert residents are helping themselves to the snacks and taking all the snacks, so there aren't any left for the other residents that can't get them on their own. V13 stated after the dietary staff leave, the kitchen is locked, and the staff don't have access to the kitchen until the dietary comes back into the facility the following day. V13 stated if the staff needed to get into the kitchen, they could call her, and she would give them the code to get into it. V13 stated she would like to have a box at each nurse's station with cookies, saltines, etc. in it for the diabetic residents that have a low blood sugar. On 1/28/25 at 11:30 AM, V1, Administrator, stated a snack cart is brought out to the nurse's station and some residents will come and get stuff off of it and the CNAs (Certified Nursing Assistants) will deliver them to the resident rooms. . On 1/29/25 at 6:20 AM, V25, Cook, stated they serve the food as follows: breakfast for the dialysis residents at 6:15 AM; breakfast for the other residents at 8:00 AM, lunch at 12:00 PM, and supper at 6:00 PM. V25 stated they serve the hall trays as follows: 100/500 hall before serving the dining room, and the 200, 300, and 400 hallways after the dining room is served. The Menu for Week 4, given to the surveyor by V1, Administrator, on 1/24/25, documents the following: dialysis snacks at 10:30 AM, special request snacks at 3:30 PM, snacks at 7:30 PM. The Frequency of Meals Policy, dated 5/2014, documents the time between a substantial evening meal and breakfast the following day will not exceed 14 hours, except when a nourishing snack is served at bedtime. Suitable, nourishing alternative meals and snacks will be provided to a resident who wants to eat at non-traditional times outside of scheduled mealtimes and consistent with the resident plan of care. A nourishing snack means food from the basic food groups, either singly or in combination with each other. The dining services director will coordinate the preparation and delivery of meals and snacks for residents that wish to eat outside of the scheduled meal and snack times. A nourishing evening snack will be provided if the time between dinner one night and breakfast the next morning exceeds 14 hours.