

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Bria of Belleville		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure physical abuse did not occur for 2 of 3 residents (R1) and (R3) reviewed for abuse in the sample of 7. 1-R1's Physician Order Sheet for August 2025 documents a diagnosis of nontraumatic subarachnoid hemorrhage, moderate protein calorie malnutrition, mucopurulent chronic bronchitis, weakness, major depression disorder, acute diastolic heart failure, pleurisy, anxiety disorder and spinal stenosis of the cervical region. R1's Minimum Data Set (MDS) dated [DATE] document R1 was cognitively intact for decision making of activities of daily living. No impairments on the upper or lower extremities and independent on most tasks and does not need assistance with some tasks. R1's Initial Incident Report dated 8/21/2025 at approximately 1:35 PM, there was an altercation between (R1) and (R3). There was no injury to either resident. The two were immediately separated. The Administrator was notified. A full investigation and a final report sent when complete. R1's Care Plan document under Abuse with the date initiated of 12/10/2024 documents, (R1) had verbal/physical altercation with another resident (no injuries) on 7/9/2025. The Care Plan does not address the resident-to-resident altercation on 8/21/2025. R1's Progress Notes do not address the resident-to-resident altercation on 8/21/2025. A Statement from V8, Certified Nursing Assistant (CNA) dated 8/21/2025 documents, I (V8) was bringing (R3) from the dining room pushing her to the room. Once there another resident was in her room. She asked (R1) to not move her curtain, then (R1) said "wait Bitc*" to (R3) then (R3) rode down on (R1) and punched her in the back, then (R1) turned around and punched (R3) in the face, then I pulled (R3) back then everything was over. On 9/19/2025 at 2:11 PM, a phone message was left for V8, but she never returned the call during this survey. A statement from V7, Infection Control Preventionist (ICP) dated 8/21/2025 documents, Around 1:15 PM, I heard a CNA screaming while standing at the back nursing station. I turned around and saw CNA (V8) holding (R3) hand and resident punched (R3) in her face. Placed myself in between both residents. Calmly asked Resident (R1) to remove herself from the room. (R1) grabbed her walker and walked out. Called (R3) a bitc*. On 9/19/2025 at 11:21 AM, V7, Infection Control Preventionist stated, I had just got to the nurse's station, and I heard a staff yelling and I turned around and saw (V8, CNA) with (R3) and saw (R1) punch (R3) in the face. I put myself between the residents and tried to calm them down. I am not aware of either one of them being aggressive. All I know is that (R1) was going into (R3's) room because she is friends with (R3's) roommate. On 9/19/2025 at 11:39 AM, R1 stated, I was friends with (R7) and she shared a room with (R3). I liked to spend time with (R7) we are friends. (R3) was upset because she would pull the curtain, and she was upset with me because I was in her room, and she called me a name and hit me in the back, so I hit her back in the face. 2-R3's August POS 2025 documents a diagnosis of type 2 diabetes morbid obesity, chronic respiratory failure, major depression disorder, anemia, hyperparathyroidism and chronic kidney disease. R3's MDS dated [DATE] document R3 was cognitively intact for decision making of activities of daily living. R3 has impairment on both her upper and lower extremities, she uses a walker and wheelchair; She requires minimal assist to supervision for most ADL's (activities of daily living). R3's Care Plan: Abuse with a revision date of 8/28/2024 document, (R3) is at risk for abuse and neglect r/t (related to) DM (diabetes mellitus), neuropathy, morbid obesity, CKD3, cardiomegaly/HTN. R3's altercation on 8/21/2025 was not addressed on her care plan. On 9/19/2025 at 11:40 AM, R3 stated, I used to be in another room. I liked to have the curtain pulled all the way. At that time (R7) was my roommate and she was friends with (R1). (R1) liked to push (R7) in her wheelchair and every time she would come into the room she would move the curtain. I told her to stop moving the curtain and she would not listen and the next time she came in the room and moved the curtain I got mad and smacked her one because she would not listen. R3's Final Report document (R3) is a [AGE] year-old female resident. She admitted (Facility) on 8/26/2024. She is alert and oriented x 4. Her BIMS (brief interview for mental status) score is 15 (15/15). She is able to ambulate short distances with a walker, but primary mode of locomotion is a wheelchair. She requires minimal assist to supervision for most ADL's (activities of daily living). Her diagnosis includes type 2 diabetes morbid obesity, chronic respiratory failure, major depression disorder, anemia, hyperparathyroidism and chronic kidney disease. On 8/21/225 at approximately 1:35 PM residents were involved in a verbal disagreement which resulted in one resident making physical contact with the other residents. Staff intervened immediately, both residents were interviewed and assessed by staff. Neither resident had any injures and both stated they feel safe in the facility. (V8) reported that she was taking (R3) back to her room and there was another resident</p>		