

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/21/2025
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide appropriate services to 1 of 1 (R6) resident investigated for dementia care in a sample of 9. Findings include: R6's EMR (Electronic Medical Record) undated documents that the resident was admitted to the facility on [DATE]. R6's EMR dated 8/5/25 documents diagnose of unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; and Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R6's MDS (Minimum Data Set) dated 11/11/25 documents a BIMS (Brief Interview for Mental Status) score of 3 out of 15. The MDS documents that the resident requires substantial/maximal assistance for roll left and right. The MDS documents that the resident is dependent for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer. R6's Nurses Notes dated 10/18/25 at 6:45 PM documents Resident was involved in abuse allegation. Head to toe assessment completed. Resident does not have any new open areas and is resting at this time. All V/S (vital signs) WNL (within normal limits). No s/s (signs/symptoms) of pain noted. MD (Medical Director), POA (Power of Attorney) and Administrator and DON (Director of Nursing) notified of allegation. Agency LPN (Licensed Practical Nurse) sent home, and investigation initiated. R6's Facility's Abuse Investigation dated 10/18/25 documents On 10/18/25 I received a call from (V28), C.N.A. (Certified Nurses Aid) and (V18), C.N.A. alleging verbal and physical inappropriate interaction by an agency LPN (V27). Physician and family notified. [NAME] Police notified. Risk completed including skin and body assessment. No injury identified. (R6) is a [AGE] year-old male resident who admitted to (facility) on 8/4/25. His diagnosis include hemiplegia and hemiparesis, L2 wedge compression fracture, moderate calorie malnutrition, aphasia, dysphagia, cerebral infarction, schizophrenia, malignant neoplasm of prostate, unspecified dementia, cognitive communication deficit. His BIMS score is 3. He is dependent for most ADL's (Activity of Daily Living). He ambulates with an unsteady gait and his primary mode of locomotion is by wheelchair. He is combative with staff and easily agitated. On 10/18/25 I received a call from (V28), and C.N.A. and (V18), C.N.A. alleging verbal and physical inappropriate interaction by an agency LPN (V27). Physician and family notified. [NAME] Police notified. Risk completed including skin and body assessment. No injury noted. (V18), (V20) reported that they witnessed Agency LPN (V27) being verbally inappropriate with resident (R6). (V20) approached (V27) and removed her from the situation while (V28) contacted management for assistance. The group kept (V27) out of resident area until the administrator called and had her sent home. (V27), LPN denied the allegation. A full investigation was completed and based on witness statements it was determined that the allegation supported inappropriate behavior. Alert residents were interviewed, and no other concerns were voiced. (V27) was suspended pending the investigation and had been blocked from being able to pick up shifts with the agency. The agency was contacted and informed of the allegation and outcome. (R6) does not appear to recall the incident. On 11/19/25 at 3:32 PM, V16, CNA stated that (R6) is her stepfather. She stated that she saw suspicious activity from the nurse on the camera that is in his room. She stated that one of the CNAs told her that this nurse was calling him a demon and that he beat women. She stated that CNA (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145668
		If continuation sheet Page 1 of 2

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also told her that the nurse pointed her finger like gun and acted like she was shooting him. She stated that her stepfather is retired pastor. On 11/20/25 at 8:58 AM, V18, CNA stated that she saw and overheard the nurse talking inappropriately with (R6). She stated that (R6) was sitting in front of the nurse's station because he can become agitated and upset. She stated that the nurse was irritating (R6) on purpose for her own amusement and then laughing at him. She stated that does not remember the exact words, but the nurse said something about (R6) not being a pastor because he has the devil or a demon inside him. On 11/20/25 at 9:32 AM, V20, CNA stated that the incident between the nurse and (R6) lasted 15 to 30 minutes. She stated that she overheard the nurse tell (R6) that he was a woman beater. She overheard the nurse tell (R6) that he is not a pastor but a demon. She stated that the nurse was laughing at him. She stated that at one time the nurse and (R6) were having a finger gun shoot out. She stated that the nurse and (R6) were both shooting at each other. She stated that if the nurse would have left (R6) alone that he would have calmed down, but she kept messing with him. She stated that she told the nurse that one of the residents was having breathing issues. She stated that nurse did not go checked on the other resident and continue to mess with (R6). She stated that she had to go get the oxygen and got the SPO2 (oxygen saturation) reading and then found another nurse.		