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	04/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to honor resident rights for 2 (R4, R13) of 3 residents reviewed for resident rights in the sample of 21.Findings Include:1.R4's Undated Face Sheet documents R4 was originally admitted to the facility on [DATE] and has a medical diagnosis of Metabolic Encephalopathy, Type 2 Diabetes Mellitus, Cognitive Communication Deficit, Lack of Coordination, Chronic Atrial Fibrillation, Heart Failure, and End Stage Renal Disease.R4's Minimum Data Set (MDS) dated [DATE] documents R4 is cognitively intact.On 4/3/2026 at 8:24 AM R4 stated the facility loses his clothing all the time and his sister brings in receipts to be reimbursed for his clothing. R4 stated he will get his clothing from Good Will because the facility tends to lose it.2.R13's Undated Face Sheet documents R13 was originally admitted to the facility on [DATE] and has a medical diagnosis of Metabolic Encephalopathy, Hypertension, Spinal Stenosis Cervical Region, Cervicalgia, and End Stage Renal Disease.R13's MDS dated [DATE] documents R13 is cognitively intact, using a motorized wheelchair and/or scooter, and has an upper and lower extremity impairment on both sides.On 4/3/2026 at 9:00 AM R13 stated the facility loses his clothing. R13 stated he sent 7 pairs of pants to the laundry and only received 1 pair of pants back. R13 stated he should not have to worry about the facility losing his clothing. R13 stated the facility has never replaced anything that he is missing and just lies to him saying they will investigate it. The Facility's Resident Council Minutes dated 1/29/26 documents Laundry: missing items and delayed.The Facility's Resident Council Minutes dated 2/26/26 documents Laundry: clothes still missing and not getting returned.On 4/3/26 at 12:00 PM V1, Administrator, stated they have had a lot of missing clothing over the past few months, their company had switched in January 2026 to a different company, prior to that they had a laundry aid that they suspected wasn't following the resident roster and was placing it where ever she could find a spot and not in the correct residents room, the old company did terminate that laundry aide and things got better. V1 stated then when the company changed to the new laundry service, that company rehired that laundry aide and again they started having problems with missing clothing, so she was terminated by the current laundry service and things are starting to get a little better.On 4/3/26 at 11:50 AM V20, Laundry Aide, stated if a resident reports missing clothing, they will get a description of the clothing item, check the lost and found first, then the residents' room, and if they still can't find it, he reports it to his manager.3. On 4/7/2026 at 9:04 AM V30, Certified Nursing Assistant (CNA), came into R13's room to answer R13's call light. V30 asked R13 what he needed, R13 asked V30 if she could apply his anti-itch cream to his back because he could not reach it. V30 stated staff are cleaning up breakfast, does not have time to do it, and she would come back later. R13 became tearful and stated every time he asks staff to help him do something they always say they will come back and they never do. R13 stated he sees staff take care of all the other residents, and when he asks for help, they never want to help him. R13 stated it makes him feel like he doesn't matter to staff. R13 stated if he could do certain things himself, he would, but he can't.The Facility's Resident Council Minutes dated 2/26/26 documents CNA: disrespectful.On 4/9/2026 at 2:37 PM V2, Director of Nursing, stated she expects staff to honor (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and follow the Facility's Resident Rights Policy.The Facility's Resident Rights Policy Date Reviewed 10/2025 documents General: The objective of the accommodation 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 preference. Procedure: The facility will assess and interview resident for the need to make reasonable accommodation such as protection of resident's personal items and supplies from loss or theft.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from verbal abuse in 1 (R13) of 3 residents reviewed for abuse in a sample of 21.Findings Include:R13's Undated Face Sheet documents R13 was originally admitted to the facility on [DATE] and has a medical diagnosis of Metabolic Encephalopathy, Cognitive Communication Deficit, Hypertension, Spinal Stenosis Cervical Region, Cervicalgia, and End Stage Renal Disease.R13's Minimum Date Set (MDS) dated [DATE] documents R13 is cognitively intact, using a motorized wheelchair and/or scooter, and has an upper and lower extremity impairment on both sides.R13's Care Plan Last Reviewed 2/2/2026 documents Abuse: R13 is at risk for abuse and neglect related currently in long term care facility, 3/20/26: Allegation of abuse.The Facility's Final Investigation Report dated 3/20/2026 documents On 3/19/25 I received a call from V9, Licensed Practical Nurse (LPN), alleging inappropriate verbal interaction by a Dialysis Technician V31. Physician and family notified. Local Police notified. V9, LPN, reported that she witnessed dialysis tech V31 being verbally inappropriate with resident R13. Following the incident V31 left the area and returned to the Dialysis Den. V31, Dialysis Tech, 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. V31 was suspended pending the investigation. Dialyze Direct was contacted and informed of the allegation and outcome R13 denied any mental anguish regarding the incident.The Facility's Abuse Investigation Resident Questionnaire dated 3/20/2026 documents On 3/20 R13 reported that the dialysis tech which he later points out to be V31 was verbally abusive to him in dialysis as well as in the hall by the nurses station. R13 stated that he felt threatened by her and the nurse heard her say that she would mess him up. R13 said he thinks she was mad because he told on her for leaving the window open and was made to close the window.On 4/3/2026 at 12:00 PM V1, Administrator, stated she had an abuse investigation that involved a dialysis technician and a dialysis patient (R13), and she did substantiate that allegation.On 4/7/2026 at 9:04 AM R13 stated he had an incident with a Dialysis worker, where the Dialysis worker threaten him. R13 stated the Dialysis tech stated she was going to beat his a** when he complained it was cold in the Dialysis room. R13 stated he informed a nurse that the tech had threatened him and when the tech came out of the bathroom, she threatened him again and that nurse heard it. R13 stated staff are supposed to be professional and help the residents not threaten them. R13 stated when the Dialysis tech threaten him, it made him feel scared, threatened, and low.On 4/7/2026 at 9:52 AM V9, Licensed Practical Nurse (LPN), stated she was at the nurse's station when R13 stated he was going to Dialysis, and he asked the Dialysis nurse if the window could be closed in the Dialysis room. V9 stated R13 told her he was threatened by V31 when R13 asked about the window. V9 stated R13 told her that V31 stated she would f*** old people up. V9 stated R13 and herself were in the hallway by the bathroom when V31 came out of the bathroom and R13 told V31 that R13 used to be a cop and you can't say that to people. V9 stated V31 repeated what R13 had said and bent down to R13's ear and stated, I f*** old people up and V31 stated she knew the camera was there and did not care about the camera.On 4/7/2026 at 10:48 AM V31, Dialysis Technician, stated she was mopping part of the dialysis floor with bleach and cracked the window due to the smell and resident's receiving dialysis. V31 stated V33, Dialysis Nurse, informed her that R13 stated he would not do his dialysis treatment due to V31 refusing to close the window. V31 stated she never refused to close the window. V31 stated she was walking down the hall to go to the restroom when she saw R13 in the hallway and jokingly told R13 she was going to get him. V31 stated when she walked out of the restroom, R13 was standing in the hall with a nurse and R13 informed her that he used to be a cop and V31 stated, yea me too. V31 stated she told R13 I'm gonna get you again and was joking. V31 stated she continued to walk down the hallway and R13 yelled at her so you are (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	going to beat my a**. V31 stated she never told R13 that she was going to beat his a**. On 4/9/2026 at 2:37 PM V2, Director of Nursing, stated she expects staff to follow the Facility's Abuse Policy.The Facility's Abuse Policy and Prevention Program Policy dated 10/2022 documents This facility affirms the right of our resident to be free from abuse, neglect, exploitation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.

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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 interview and record review the facility failed to appropriately document the administration of an opioid medication for 1 (R5) of 6 residents reviewed for pharmacy services in a sample of 21.Findings include:R5's Undated Face Sheet documents R5 was originally admitted to the facility on [DATE] and has a medical diagnosis of Type 2 Diabetes Mellitus, Altered Mental Status, End Stage Renal Disease, Osteomyelitis, and Hypertension.R5's Minimum Data Set, dated [DATE] documents R5 was moderately impaired.R5's Care Plan Last Review Date 3/9/2026 documents R5 has an alteration in comfort related to Advanced Disease Process, Hypoxic Ischemic Encephalopathy, Osteomyeltities, Pressure Ulcers, Gangrene.R5's Physician Order dated 1/10/2026 at 6:16 AM documents Oxycodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth every 4 hours as needed for Pain.R5's Medication Administration Record (MAR) dated 1/1/2026-1/31/2026 documents R5 received his ordered dose of Oxycodone-Acetaminophen 10-325 mg on 1/10/2026 at 7:15 PM and 1/12/2026 at 8:34 PM.R5's Oxycodone-Acetaminophen 10-325 mg Medication Monitoring/Control Record documents R5 received a dose of Oxycodone-Acetaminophen 10-325 mg on 1/10/2026 at 7:10 PM, 1/10/26 at 11:30 PM, 1/11 at 9:00 AM, 1/11 at 8:34 PM, 1/12, 1/13 at 8:00 PM, 1/14 at 5:00 AM, 1/14/2026 at 8:00 PM, 1/15/26 at 1:30 AM, 1/15/26 at 6:30 AM, and 1/15/26 at 3:20 PM.R5's Investigation Dated 1/16 documents R5 was administered his medication on 1/10 at 7:00 PM and 11:30 PM, on 1/11 at 9:00 AM and 8:30 PM, on 1/12 at 2:00 AM, on 1/13 at 8:00 PM, on 1/14 at 5:00 AM and 8:00 PM and on 1/15 at 6:30 AM and 3:20 PM.On 4/9/2026 at 10:15 AM V2, Director of Nursing, stated R5's MAR does not match R5's Oxycodone Medication Monitoring/Control Record, and R5's MAR does not document all dates the medication was administered. V2 stated nursing staff should document that a medication was administered on the resident's MAR. V40, Licensed Practical Nurse/Charge Nurse, stated if a medication is given, including a narcotic, it is documented on the resident's MAR. V2 stated she expects staff to document that a medication was given on the resident's MAR.The Facility's Medication Administration Policy Last Revised 5/2017 documents document as each medication is prepared on the MAR.