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	05/29/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record resident review, the facility failed to revise a resident's comprehensive care plan for Leave of Absence for care plans for 4 of 4 residents (R2, R3 R4 and R6) reviewed for care plans in the sample of 8.Findings include: 1-R2's Physician Order Sheets (POS) dated [DATE] documents a diagnosis of Schizophrenia, unspecified; major depression disorder, recurrent moderate; unspecified psychosis not due to substance or known physiological condition, cellulitis of neck, iron deficiency anemia, prediabetic, thrombocytosis; unspecified burn of unspecified degree of multiple sites of head, face and neck, subsequent encounter. May attend day program. May go out on pass with medication with family. R2's Care Plan with a Date initiated [DATE] to current does not document anything related to being able to sign himself out and/or leave the facility. 2-R3's POS dated [DATE] documents a diagnosis of generalized anxiety disorder, hyperglycemia, unspecified, person injured in collision between other specified motor vehicles (traffic), type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema, and major depression. R3's POS also documents R3 May attend day program. R3's Minimum Data Set (MDS) dated [DATE] document R3 was cognitively intact for decision making of activities of daily living. R3 has no behaviors, no impairments and does not use a wheelchair. On [DATE] at 7:03 PM, R3 stated he did own a car, and it was a Ford Fusion, and it was parked on the side of the building. His car was currently not running and he needed to get it fixed. My health has not been that good, so I am not really driving the car either. He stated he is able to leave the facility whenever he wants to go and come back. R3's Care Plan dated [DATE] does not address him coming and going and/or leaving the facility. 3-R4's POS dated unspecified severe protein-calorie malnutrition, other abnormalities of gait and mobility, dysphagia, oropharyngeal phase, unspecified severe protein-calorie malnutrition, depression, bipolar disorder, altered mental status, unspecified personality disorder, and weakness. R4's POS also documents, May go to day programs and May go out on pass with medications with family. R4's POS does not document he may come and go on his own or take a LOA (leave of absence). R4's Care Plan does not address any LOA activity R4 may participate in. On [DATE] at 8:45 AM, R4 stated he does have a car here that he uses and he likes to visit his family and friends. No issues. No issues with staff not being available or signing in and out. He comes and goes as he wants. 4-R6's POS for [DATE] documents a diagnosis of cerebral infarction, type 2 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with hyperglycemia, transient cerebral ischemic attack, anxiety disorder, other specified disorders of brain, weakness, and tachycardia. R6's POS also documents May attend day program and May go out on pass with medication with family. R6's Care Plan with a Date initiated [DATE] to current does not document anything related to being able to sign out and/or leave the facility for LOA. On [DATE] at 4:43 PM, R6 stated she goes out to visit her family and friends and signs herself in and out. On [DATE] at 12:33 PM, V57, MDS/Care Plan, and V58, MDS/Care Plan both stated they were not sure what ?May attend day program' means and were not aware of any resident attending a day program. They had not Care Planned any resident for LOA but if they had an order for a LOA then they would care plan it. If a resident was cogntively intact, then they would think they (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be able to come and go, but only if they had an order for it. ?May go out with pass with medication and family' they would consider a resident going out and doing a family activity and/or a visit. On [DATE] at 6:24 PM, V1, Administrator stated, (R1, R2, R3 and R4) all had cars here that are still on the premises. (R1) expired and his family came and picked up the car. (R2, R3 and R4's) cars are still on the property. R2, R3, R4 and R6 can all come and go and sign themselves out. The Facility Care Plan with a revision date of 3/2026 documents, The facility must develop a comprehensive person-centered care plan for each resident. The care plan will include a focus, measurable goal, and interventions specific to the residents' medical, nursing, mental, and psychosocial needs. The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial function based on the comprehensive MDS assessment.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility failed to ensure critical sign-out procedures were implemented and followed for 1 of 5 residents (R2) reviewed for elopement in the sample of 5. R2 had expressed his desire to leave the facility. This failure resulted in R2 leaving the facility on 5/3/2026 around 6 PM, without proper authorization and staff thinking R2 would be returning to the facility, and nothing was reported until the following day at 6 PM on 5/4/2026. This failure resulted in a delay in reporting and as of 5/27/2026, R2 still has not been found, and remains missing. This past non-compliance occurred from 5/3/2026 to 5/6/2026. Findings include: R2's Physician Order Sheets (POS) dated May 2026 documents a diagnosis of Schizophrenia unspecified; major depression disorder, recurrent moderate; unspecified psychosis not due to substance or known physiological condition, cellulitis of neck, iron deficiency anemia, prediabetic, thrombocytosis; unspecified burn of unspecified degree of multiple sites of head, face and neck, subsequent encounter. R2 was prescribed Ativan 0.25 mg (milligram) (Lorazepam), give 0.25 mg by mouth twice a day for compulsiveness. Cleanse scar tissues to back/neck with normal saline then apply silicone boarded dressing as preventive measure. (To stop pt (patient) from scratching, every day shift, for preventative). Risperidone oral tablet 1 mg, give 1 tablet by mouth two times a day for schizophrenia. May attend day program. May go out on pass with medication with family. R2's POS does not document R2 may come and go in and out of the facility as he pleases and/or without supervision. R2's Minimum Data Set (MDS) 4/11/2026 document R2 was cognitively intact for decision making for activities of daily living (ADL's). R2 has no impairment and needs minimal assistance for most ADL's. R2's Care plan documents (R2) requires some assistance with daily care needs. He ambulates about facility with supervision. Date Initiated: 7/3/2025. [NAME]: (R2) is at risk for complications r/t DX (related to diagnoses of) anemia. (R2) is at risk for skin complications r/t (related to) Burn of unspecified degrees of multiple sites of head, face, and neck. Date initiated 5/9/2024. Discharge Planning: (R2) expresses the desire for the resident to continue long term. The resident's discharge potential and discharge planning needs have been assessed by the IDT (intradisciplinary team) and it has been decided to continue long term care, Date initiated 7/9/2025. Intervention: Continue to monitor and document all progress. (R2) has criminal behavior. (R2) has demonstrated stability during the admission screening process, does not appear to present an unusual risk. Aggravated unlawful use of weapons. Date initiated 7/3025. (R2) would like to move to a less structured environment. (R2) discharge potential and discharge planning needs have been assessed by the IDT (intradisciplinary team), Data Initiated 7/3/2025. Ambulation: Walk to dine to maintain endurance and mobility. Date initiated 7/3/2025. On 5/20/2026 at 5:40 PM, when entering the facility, the doors from the entrance to the residents' halls were locked and one needs a code to enter the resident area and a different code to exit. Two codes are needed to come and go into the resident's hall. One code is needed to enter, and another code is needed to exit. R2's Progress Notes dated 4/21/2026 at 1:54 PM (LATE ENTRY actually created on 5/6/2026 at 2:01 PM), Resident voiced to social service directors that he was wanting to discharge to a shelter. Resident stated he felt suffocated in his room and just wanted to go back to the shelter he was at before. SSD (Social Service Director) educated resident it was not a safe discharge and how he needs wound care and how they would not have that at the shelter. Resident voiced understanding and said he was just going to stay. SSD told resident if he was continuing to feel that way to let us know. SSD told him that I would have psych (psychiatry) review his medications if that could help him. Resident appeared OK with that and voiced understanding of needing to be here for his wound care at this time. R2's Progress Notes dated 4/21/2026 at 3:03 PM, Resident verbalized desire to leave the facility against medical advice (AMA) at this time. Resident expressed feelings of depression and stated intent to leave. Writer spoke with resident regarding (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risks associated with leaving AMA and provided education on safety concerns, continuity of care, and available support service. Emotional support and reassurance provided. Resident agreed to remain in facility at this time following discussion. Resident has been added to the list to follow psych. On 5/27/2026 at 12:01 PM, V28, Former Nurse Practitioner stated, she no longer works for the facility. She remembers (R2) was a young man and at that time she saw him he was not symptomatic, but he was also on medication and was stable. I only saw him twice. He shared with me an event when he was homeless. He was on risperidone. That's all I can remember. I cannot say if stopping the medications would be detrimental to his health as it may or may not be, it's hard to say. He would need the diagnoses to determine this. On 5/27/2026 at 12:05 PM, V29, Social Service Director stated (R2) came to us about a month ago asking if he could go to a shelter. He said he wanted to go back to the shelter where he was at one time. He did not remember the name, and I was not sure where it was or even what town it was located at. We talked about him wanting to leave and I documented it in his chart. He seemed fine after that. We had the Nurse Practitioner (V28) see him when she came to do her rounds and he seemed fine after that. R2's Progress Notes (LATE ENTRY) dated 5/3/2026 (but actually created on 5/5/2027 at 8:17 PM), at 6:30 PM, Resident reported to CNA (Certified Nurse Aide) he was going to the laundromat down the alley. Resident remains alert x 4. Shows no signs of distress or discomfort, no new concerns noted at this time. On 5/26/2026 at 8;22 AM, V11, Certified Nursing Assistant (CNA) stated, I saw (R2) coming down the hall on Sunday 5/3/2026 and he had two clear bags of clothes with him and was walking down the hall. I asked him where are you going and (R2) said he was going to the laundromat to wash his clothes. (R2) comes and goes as he pleases, and I was at the nurse's station and was not at the entrance way. (R2) keeps to himself mostly, and if you talk to him, he will talk to you. I never told any nurse or reported to anyone that I saw him leaving until we found out later, he was missing. I have never known him to take his clothes to the laundromat before. Normally, we do have everyone sign off at the receptions desk. Having residents sign in and out is not my responsibility. I never reported (R2) leaving because I thought he was going to do all that with the receptionist because he always has in the past. I did not know until afterwards there was no receptionist working at that time. I have never known (R2) to take his clothes to the laundromat. R2's Progress Notes dated 5/4/2026 at 7:19 PM, While receiving report from the day shift nurse this nurse was informed that resident had left facility the night before around 6:30 PM, going to the laundry mat. Day shift nurse stated to this nurse that she had not seen resident today on her shift. This nurse reported to (V3, Assistant Director of Nursing). On 5/22/2026 at 2:46 PM, V10, Licensed Practical Nurse (LPN) stated, I was working the 7AM to 7PM shift the day (R2) got out. At the start of each shift, they give us a report and (R2) was marked as LOA (leave of absence). At first, I was not concerned because the report paper said (R2) was out on leave, at the laundromat. I kept coming back and forth and checking to see if I could find him because he needed his medicine. I was not sure when he left or when he was coming back. After my shift ended at 7 PM, (R2) was still was not back and I started asking questions like when was he coming back, and that's when we found out (R2) had not signed out or told us when he would be returning. (R2) was always nice to me and talked with me. He never told me he wanted to leave or that he was unhappy. I was told he still has not come back and is still missing. I do not believe I ever saw (R2) take his clothes to the laundromat. V10's statement dated 5/5/2026 at 2:14 PM, documents, Tell me what happen on 5/3/2026 during your shift. Did you look for the resident? ?She read report sheet that stated (R2) was on LOA'. Resident is known to leave and is independent. Due to that she didn't feel that it was an immediate concern as this wasn't abnormal for him. She gave report to the night shift nurse that he was LOA. On 5/20/2026 at 6:30 PM. V1, Administrator stated, (R2) told staff on 5/3/2026 around 6 PM, that he was going to the laundromat and he left with two bags and has never returned. (R2) is still missing. I talked with his former roommate, and he told me (R2) told him he was going to a shelter. We watched the camera footage and (R2) walked out of the facility towards the laundry mat and never returned. I notified his family, and we have been attempting to contact shelters, and I alerted the police. The police have a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	national registry for missing people (CODAS) and (R2) is on the list now. (R2's) family was not close to him. He did have a grandma that he was close with and went to her house and (R2) was not there. (R2) is ambulatory and alert and orientated. He was here because he suffered some burns, and he had been here for a little bit and then went and lived with his grandma, and then his wounds opened back up, so he came back here. (R2) likes to pick at his wounds. We contacted the police and shelters, the hospital and morgue. (R2) also had a sister that did come sometime last year to visit him. In the past (R2) would sign himself in and out. This time was a Sunday and there was no staff at the front desk, and he left with his two bags. He does have a car outside, it is a white Chevrolet. I am not sure if it will run, but it looks like a decent car. We did not consider (R2) an elopement because he told us where he was going. I am not sure if (R2) actually went to the laundry mat, or if they have cameras. In the past (R2) had talked about wanting to go to a shelter, and I explained to him that that would not be safe and would not be a safe discharge. The only way he could do that would be if he signed out AMA (against medical advice). This was a few weeks before he left. He had gone out that day earlier and came back with no issues. Again, he was always signing himself in and out. As of today (R2) is still missing and has not been located. On 5/26/2026 at 9:21 AM, V9, Licensed Practical Nurse (LPN) stated, I saw (R2) earlier in the day, and he seemed okay. He keeps to himself mostly and when I went to do rounds around 6:00/6:30 PM on Sunday 5/3/2026, (R2) was not in his room. I went around and was asking staff if they had seen him and (V21, Certified Nursing Assistant (CNA) told me she had seen him, and he told her he was going to the laundromat. (R2) comes and goes all the time. (R2) cannot even get out of the building unless he knows the code or someone buzzes him out because those doors are locked. I am not aware of him ever taking his clothes to the laundromat before. At that time, I did not think (R2) was missing. Normally, we have a receptionist, and they have the residents sign in and out and tell us when they are coming back. Because (R2) signed in and out when I gave my report, I said he was at the laundry mat and did not think this as a concern because he was always coming and going. I never looked at the sign out sheets, I just assumed he signed out with the receptionist. I did not realize the receptionist staff had called off that night. On 5/26/2026 at 7:55 AM. V22, Receptionist stated she had been working in the facility for about five or six years as a receptionist. If she has a resident who wants to go out with their family or go out on their own, like to a store, then they have to fill out two forms. The first form is the ?Release of Responsibility Form' required during any leave of absence. The form has their name, signature and tells us where they are going and when they are coming back. Then we have a tracking form that says who is out of the building, date, the date of the leave of absence, planned return, signature, date returned, return time of LOA and when they are coming back. Typically, if a resident wants to leave, then I contact the nurse and run everything with her to make sure they can leave. (R2) has a history of coming and going. He was always leaving and going somewhere. I never knew him to take his clothes or say he was going to the laundromat. The day he left I worked the first shift 7 AM to 3 PM. There was supposed to be another receptionist from 3 PM to 8 PM, but they called off so there was no receptionist that was working when he left that day. I told the nurses to keep an eye on the residents since the receptionist called off. To my knowledge (R2) is still missing. On 5/27/2026 at 8:40 AM, V23, Business Office Manager stated we were in the process of hiring another receptionist and I had said I could work on 5/3/2026 from 3 PM to 8 PM, but then I had a family emergency and was not able to work on any of that schedule. To my knowledge, no other staff was able to cover that shift and that was the day (R2) left the facility. I was supposed to be working that shift when (R2) left without signing out and no other staff member was working the front desk. On 5/22/2026 at 3:44 PM, V3, Assistant Director of Nursing stated, Typically, (R2) was really good about signing himself in and out. (R2) told (V21, CNA) that he was going to the laundromat and had some bags in his hands. Typically, we have a staff member housed at the front desk and they sign residents in and out when they are going on a LOA (leave of absence), and this happened around 6PM, shift change and the replacement staff was late so nobody was at the front desk to sign (R2) out and nobody knew when he was going (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to come back. V3's statement dated 5/5/2026 no time documents, See attachment, it was reported to this writer at approximately 8:00 PM on 5/4/2026 that resident had not been observed in the facility since approximately 6:30 PM on 5/3/2026. Per report, resident was last seen leaving the facility stating intent to go to a nearby laundromat. It was further reported that resident returned to the facility later that evening and subsequently left again; exact times of return and second departure are unknown. NP (Nurse Practitioner)/physician, DON and administrator were notified immediately upon awareness. Resident's family was contacted and reports no knowledge of resident's location. Local hospitals and shelters were contacted with no success in locating resident at this time. Police department was notified and missing person report filed per administration. On 5/22/2026 at 4:02 PM, V2, Director of Nursing (DON) stated the nurse (V26, LPN) was completing her rounds when she noticed (R2) was not in his room. She asked the CNA if she had seen him. (V21 was the CNA). (V21) told the nurse she saw (R2) leaving around 6:30 PM, he had two bags and said he was going to the laundromat. (R2) has a history of coming and going, so nobody thought anything of it. The receptionist that was supposed to be working the desk called off, so there was no staff member at the desk. The next day the nurse was concerned and contacted V3 himself. V2 statement dated 5/5/2026 at 11 AM, Documents, Nurse was completing her 6:00 PM rounds when she notified that the resident (R2) was not in his room. She asked the hall CNA if she had seen (R2) and she stated that he left around 6:30 PM to go to the laundromat. It was normal for him to leave the facility. She was not concerned at that time. She reported it to the oncoming night shift nurse that (R2) was LOA. On 5/27/2026 at 10:02 AM, V1, stated, I am not sure how (R2) got through the doors. I am not sure if he figured out the code or if someone buzzed him through the doors. On 5/27/2026 at 8:57 AM, V26, Agency LPN stated, When I started my shift the day shift nurse was reading an old report, and she hadn't the time to make a new report. She started going down the list and several residents were marked LOA. When she got to (R2) he had LOA next to his name written and I asked her if he was still gone because it did not make sense to me because they said he was at the laundromat, and I was asking if anyone had seen him because by this time he should have been back in the building. The CNA's work eight-hour shifts and the nurse's work 12-hour shifts and I started asking if anyone had seen him. Nobody had seen (R2), and I told the nurse to call her supervisor and let them know because it has been over 24 hours and that is an elopement, and he has been missing, and administrator needs to know and to call somebody. I went into (R2's) room, and he had pills that were lying on his desk. I believe it was lorazepam and some other pills. We are never supposed to leave medications lying around and are supposed to always watch the residents take their medications. I am not sure why the pills and medications were in his room. I asked the nurse if she wanted me to do something else, then about an hour later the police showed up and I walked the policewoman to his room, and she took some pictures. I told her as I am telling you this was my first day working in the building and I was not familiar with (R2). The police talked with his former roommate, and I believe he told them (R2) came and said goodbye to him and that he wanted to leave the facility. I put in a note in his chart, and alerted others to (R2's) elopement. R2's Incident Report documents, Incident Type: Missing Resident-Unauthorized Departure. Incident Overview: On May 3, 2026, at approximately 6:00 PM, resident (R2) departed the facility without proper authorization and has not returned as of the date of this report. The resident was initially believed to be on an authorized leave of absence based on his established pattern of voluntary departures: however subsequent investigation revealed that proper sign-out procedures were not followed. The facility has implemented comprehensive search efforts and notified all appropriate authorities. Current status: Resident remains missing. Active search efforts continue with law enforcement, healthcare facilities, and community organizations. Police report filed with local authorities on May 4, 2026, at approximately 11:00 PM. Immediate Safety Concerns: Resident has documented history of mental health conditions including schizophrenia, psychosis, major depression disorder, and major depression which may impact his ability to care for himself independently. Iron deficiency condition may also affect his physical well-being during extended (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	absence. Departed with two bags of clothing. The resident has the following documented medical conditions that create safety concerns during his absence and require immediate medical attention if located: Iron deficiency: Ongoing condition requiring medical monitoring and potential treatment. Schizophrenia: Chronic mental health condition requiring consistent medication management and psychiatric care. Psychosis: Active psychiatric condition that may impair judgment and decision-making capacities. Major depression disorder, Recurrent, Moderate: Mental Health requiring ongoing therapeutic interventions and medication management. These conditions collectively create significant safety risk during unauthorized absence including potential for self-harm, inability to seek appropriate medical care, medication, non-compliance, and impaired capacity to make safety decisions regarding shelter, food and personal safety. R2's Police Report dated 5/4/2026 at 6:00 PM, document On 05/04/2026 at approximately 10:06 PM, I, (V23, Local Police Officer) responded to (Facility) in reference to a missing person. Dispatch advised the caller, later identified as (V1, Administrator) stated a resident, later identified as (R2) left the facility yesterday (05/03/2026) at approximately 6:30 PM, hours. (V1) was informed by a roommate of (R2's) that he was going to a shelter. I arrived on the scene and made contact with staff, identified as (V26, LPN). V26 stated the following, not verbatim: This is her first night at (Facility). She is in control of the wing that (R2) resides in. She was told by the day shift nurse, whom she knows as (V10) that (R2) has not been at the facility since last night, 05/03/2026, at approximately 6:30 PM. She told the administrator, (V1). She does not know anything about (R2). She went into (R2's) room and saw his medications sitting bedside from the night before. She knows she was told by the day shift nurse that (R2) can sign himself in and out. (V26) printed out a face sheet with (R2's) information. I noted that (R2) had a listed history of schizophrenia and major depressive disorder. I requested (V25) to provide (R2's) last brief interview mental status (BIMS) to determine his cognitive impairment. I reviewed the last BIMS report from 04/10/2026; (R2) scored a 15/15, demonstrating intact orientation, attention, and short-term memory at the time of the assessment. (V25) guided me to (R2's) room. I did not locate anything of evidentiary value. I photographed the room and later placed the photos into the case file. (V25) was advised by other staff members that (R2) did not have a roommate at this time. (R2) had a previous roommate, later identified as (R5). I met with (R5) and he stated the following, not verbatim: V23, Local Police talked with (R5) and he stated the following: He last talked to (R2) on either Friday (05/01) or Saturday (05/02). (R2) told him that he did not want to be at the facility anymore. He tried to get (R2) to stay at (Facility) and told him that he was moving back in the room with him. (R2) told him that he got a spot at a shelter and wanted to stay there. (R2) further told him that if he did not go, the shelter would give his spot away. (R2) did not say what shelter he was going to. (R2's) grandmother lives in the area. He does not know about (R2's) brother, but his sister lives out of town. On 5/26/2026 at 1:31 PM, R5 stated he was roommates with (R2), but I had an infection, so they moved me. We were friends and they talked. (R2) told him he wanted to leave, and (R2) told him he was going to leave and go to a shelter, but he told me this on Saturday but then he was still here. So, I was not sure he was for real. Then I found out he left on Sunday and has not been back. (R2) did not tell me the name of the shelter. I do not know if he is safe. He has not contacted me since he left. The LOA tracking form for 5/3/2026 does not document R2 signed himself out on 5/3/2026. Despite R2's established pattern of authorized departures, proper documentation protocols were not followed on 5/3/2026. R2 was missing sign-out documentation. No entry was found in facility sign out book for 5/3/2026, or any subsequent date. Staff assumed R2's departure was authorized based on resident's historical pattern of coming and going without following up and ensuring/verifying the proper documentation was actually in place. The information shared was passed between shifts without any staff checking the LOA book and verification of authorization status for R2 leaving. R2's Medical Records document R2 had expressed to the facility that he wanted to leave but no interventions were put into place to ensure R2 was safe and had a safe discharge. On 5/27/2026 at 10:23 AM, V27, Psychiatric Doctor stated he would expect the facility to follow all sign out/supervision policies for (continued on next page)

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	05/29/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all of the residents. On 5/27/2026 at 11:42 PM, V27 stated he oversees the Nurse Practitioners, but he is not on the ground providing care. If a resident stops taking medications and the patient is stable, we do a gradual dose reduction before just taking them off the medications. It is hard to say if there would be harm as it could be minimal harm or possibly more depending on the resident. It just depends on the resident. Some residents may have a diagnosis that they got at the hospital, and it was an inaccurate diagnosis. Other residents could potentially be affected if it was an accurate diagnosis. I am not sure with (R2) because I never saw him. The possibility of harm with a psychiatric resident not receiving their medications as ordered and if they needed it could be harm but only if it was an accurate diagnosis. R2's Physician Admission/Follow up Schizophrenia Diagnosis Confirmation Evaluation Form dated 4/27/2026 documents, R2 has had previous hallucinations, assessment of hallucinations: More currently present with current medication management. Patient states I started to hear a lot of voices in a crowd around 2014, R2 was documented as meeting the criteria for the DSM-5-TR (The Diagnostic and Statistical Manual of Mental Disorders) criteria of schizophrenia. (This diagnosis was completed by V28). The Facility Leave of Absence Policy with a revision date of 3/11/2026 documents, This policy outlines the procedures for documenting and managing resident Leaves of Absence (LOA) to ensure resident safety, regulatory compliance, and continuity of care. Residents have the right to leave the facility for therapeutic or personal reasons. A physician's order is required prior to any Leave of Absence. For therapeutic leave, the facility is not obligated to hold the resident's bed; however, the resident retains the right to return to the next available bed in a semi-private room, even if there is a waiting list. The facility must provide written information about bed-hold and return rights to the resident or their representative upon admission and at the time of any leave. A physician's order must be obtained prior to the resident taking Leave of Absence. The resident or responsible party must notify the nurse of their destination and estimated return time. The resident or responsible party must sign out using the facility's Sign-Out Sheet. If medications are to be taken during the LOA, the nurse must verify the order, provide labeled medications, and give instructions. If the resident is delayed in returning, the responsible party should notify the facility. If the resident does not return as anticipated, nursing staff must attempt to contact. If unsuccessful, the DON and/or Administrator must be notified and for further instructions. If the resident fails to return and no contact is made, the physician must be notified and the situation may be documented as a discharge Against Medical Advice (AMA), if appropriate. The party responsible must be notified within 24 hours of any failure to return. The past noncompliance began on 5/3/2026 and was corrected on 5/6/2026 after the facility took the following actions to correct the noncompliance. The DON/Designees provided in-servicing on Elopement and Supervision, Rounding and Providing care for the Resident, Identifying Residents that Wander and Exit Seekers, Alarm Codes and LOA and AMA Policy to all staff and agency staff on 5-5-26. In-service is ongoing, and all staff and agency staff who were not present on 5-5-26 will be in-serviced prior to the start of their next scheduled shift. The DON/Designees provided in-serving on Change in Condition and Medication Administration to licensed staff and licensed agency staff on 5-5-26. In-servicing is ongoing and will be in-serviced prior to the start of their next scheduled shift. The Maintenance Director inspected all facility door alarms and confirmed they were functioning appropriately on 5-5-26. The Maintenance also called (door alarm company) to assist with changing facility door alarm codes on 5-5-26. The alarm codes were successfully changed on 5/5/26. All residents were reassessed by the Clinical Leadership Team, using the Elopement Risk Assessment Tool and this was completed on 5-5-26. All residents identified as at risk for elopements have had their care plans reviewed by the MDS nurses for resident specific interventions. This was completed on 5/6/26. An elopement binder was reviewed by the Regional Nurse Consultant, to ensure those residents at risk for elopement, have a face sheet and picture in the binder. 5-5-26. The Facility has implemented a 24/7 front desk receptionist on 5-5-26 (until can ensure doors. The IDT will review if the need for a 24/7 receptionist is still warranted weekly during QA meetings. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent an adverse outcome from reoccurring. (Completion Date: 5-6-26). The DON/Designee will in-service staff and agency on facility elopement policy, on Elopement and Supervision, Rounding and Providing care for the Resident, Identifying Residents that Wander and Exit Seekers, Alarm Codes and LOA and AMA on 5-5-26. The DON/Designees provided in-serving on Change in Condition and Medication Administration to licensed staff and licensed agency staff on 5-5-26. In-servicing is ongoing and will be in-serviced prior to the start of their next scheduled shift. The MDS/DON/Designee will review all new admissions within 24 hours after admission for elopement risk 5 days a week for 4 weeks, any residents who trigger as high risk will be place in the elopement binder along with care plan with resident specific interventions. The DON/MDS/designee will review all elopements at the daily stand-up meeting with the IDT for three months to ensure appropriate elopement interventions are implemented, the resident's care plan has been reviewed and revised, and the individualized service plan The DON/MDS/designee will review 5 resident MARs/TARs weekly for 4 weeks, monthly for the next 3 months for proper documentation and following physician orders. QAPI meeting was held on 5/6/26 with IDT and MD. A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring/auditing and reporting will continue for a minimum of three months.

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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. Based on interview and record review the Facility failed to ensure no medication was left unattended on a bedside table for 1 of 3 residents (R2) reviewed for unattended medicine in the sample of 8. This past non-compliance occurred from 5/3/2026 to 5/6/2026. Findings include: R2's Physician Order Sheets (POS) dated May 2026 documents a diagnosis of Schizophrenia unspecified; major depression disorder, recurrent moderate; unspecified psychosis not due to substance or known physiological condition, cellulitis of neck, iron deficiency anemia, prediabetic, thrombocytosis; unspecified burn of unspecified degree of multiple sites of head, face and neck, subsequent encounter. R2 was prescribed Ativan 0.25 mg (milligram) (Lorazepam), give 0.25 mg by mouth twice a day for compulsiveness and risperidone oral tablet 1 mg, give 1 tablet by mouth two times a day for schizophrenia. R2's Police Report dated 5/4/2026 at 6:00 PM, document On 05/04/2026 at approximately 10:06 PM, I, (V23, Local Police Officer) responded to (Facility) in reference to a missing person. Dispatch advised the caller, later identified as (V1, Administrator) stated a resident, later identified as (R2) left the facility yesterday (05/03/2026) at approximately 6:30 PM, hours. I arrived on the scene and made contact with staff, identified as (V26, Agency Licensed Practical Nurse (LPN)). V26 stated the following, not verbatim: This is her first night at (Facility). She is in control of the wing that (R2) resides in. She does not know anything about (R2). She went into (R2's) room and saw his medications sitting bedside from the night before. (V25) guided me to (R2's) room. I did not locate anything of evidentiary value. I photographed the room and later placed the photos into the case file. On 5/27/2026 at 8:57 AM, V26, Agency LPN stated, I went into (R2's) room, and he had pills that were lying on his desk. I believe it was lorazepam and some other pills. We are never supposed to leave medications lying around and are supposed to always watch the resident take their medications. I am not sure why the pills and medications were in his room. On 5/28/2026 at 11:11 AM, V1, Administrator stated, We identified concerns with (R2's) medication being left on his bedside table. No staff should ever leave medication behind and should always pass out the medication only to the resident, and if the resident is not there, the medicine should not leave the cart. On 5/28/2026 at 11:33 AM, V2, Director of Nursing (DON) stated, I would not expect any of the nurses to leave any residents medication on the table. All staff should administer the medication and watch the resident take their medication and never leave any medication in their rooms. The Medication Administrator Policy dated 10/2025 documents, Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. Prior to the survey date, the Facility took the following actions to correct the noncompliance on 5/6/26. Immediate Actions: 1-Director of Nursing, Assistant Director of Nursing, and/or Designee immediately in-serviced all nurses regarding Medication Administration to include accurate identification of patient/resident prior to medication administration and not leaving medications out.2-Director of Nursing, Assistant Director of Nursing, and/or Designee immediately initiated ongoing audits of medication administration per clinical managers to ensure that nurses are compliant with Medication Administration to be immediately addressed upon identification and/or re-education provided. 3- QAPI meeting was completed to review occurrence, immediate intervention, and plans for ongoing audits to ensure continued compliance. Ongoing Actions: 1-Education will be provided to new employees prior to being allowed to work in the Facility. 2-Concerns will be addressed immediately and discussed during the monthly QAPI Committee for resolution.