STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145717	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Columbia	253 Bradington Drive Columbia, IL 62236

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 - Immediate jeopardy to resident health or safety 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** 50628 Based on interview and record review, the facility failed to prevent resident verbal and physical abuse for 1 of 8 residents (R2) reviewed of abuse in a sample of 8. This failure resulted in an Immediate Jeopardy on 12/19/24, when V6, R2's brother, who was known to have a history of abusing R2, was allowed to have unsupervised visits with R2 and verbally abused her. Subsequently, on 12/29/24, V6 verbally and physically abused R2. Using a reasonable person concept, this would have caused psychosocial harm resulting in feelings of being unsafe, sadness, fear, and humiliation. The Immediate Jeopardy began on 12/19/24, when the facility failed to prevent V6 from verbally abusing R2 and implement interventions to prevent future abuse. On 12/29/24, V6 again verbally and physically abused R2. On 1/7/25, at 11:00 AM, V2, Assistant Administrator, and V3, Director of Nursing (DON), were notified of the Immediate Jeopardy. The surveyors confirmed by interview and record review, the Immediate Jeopardy was removed on 1/9/25, but remains at a level two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R2's Face Sheet, undated, documents she has diagnoses of metabolic encephalopathy, severe protein-calories malnutrition, diabetes, dementia, schizoaffective bipolar disorder, severe intellectual disabilities, Down syndrome, and vascular dementia. R2's Minimum Data Set, (MDS), dated [DATE], documents resident is severely cognitively impaired with minimal hearing deficit. R2's MDS documents she requires substantial assistance with eating, and is dependent on staff for all other activities of daily living, (ADL's). (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Care Plan, dated 12/21/24, documented R2 is at risk for abuse and neglect due to cognitive impairment and use of psychotropic medications. Care plan interventions include assuring resident is in a safe and secure environment. The goal is that staff will monitor well-being of others and R2 will have zero episodes of abuse and neglect throughout next review. On 4/19/24, the care plan documented V6 visitation is to occur only with window visits and phone visits supervised by staff. Also assess R2 for abuse and neglect upon admission and quarterly, assure resident that she is in a safe and secure environment with caring professionals, assure resident she is in a safe and secure environment with caring professionals, assure resident staff members are available to help, continue to in-service the staff about abuse and neglect, identify areas that put resident at risk, immediately report any episodes of unknown injury, abuse or change in R2's behavior for immediate intervention and review, monitor for any changes in behavior during and following V6 visits, observe the resident for signs of fear and insecurity during delivery of care. No further interventions regarding visits are documented in the care plan. Facility's initial report phoned to the state hotline documented, On 12/29/24 at 1 pm, (V6), (R2's) brother, came into the facility and beat (R2). (V6) put his hands on (R2's) face and said, 'hold your head up or I will break your f****** neck.' (V1, Administrator), called police and police stopped (V6). (V6) was suspended and cannot come into the building until the investigation is complete. V6 was previously banned, and this appears to be an ongoing issue was also documented on the intake investigation. R2's Progress Notes, dated 12/29/24 2:40 PM, documented by V8, Licensed Practical Nurse (LPN), stated it was reported to her by V7, LPN, that V5, Certified Nurse's Aide (CNA) had reported to her that V6 was feeding her lunch and yelled I will break your f****** neck. When V5 went into check on R2, V5 stated V6 had shoved R2's head. The note documented V1 and V3 were notified. R2's Progress Note on 12/29/24 at 2:47 PM, documented V5 reported to V8 that V6 was feeding R2 and yelled using profanity, and stated he would break her neck, and when V5 entered the room she stated she saw V6 shove her head. V5 then told V7. On 12/29/2024, a written witness statement was provided by V5, which documented on 12/29/24, around noon, she was sitting at the nurse's station across from the main dining room. V5 documented she overheard V6 yelling very angrily and aggressively. V5 heard V6 him say, I will break your f***** neck. V5 decided to check on R2, and as she walked into the doorway of R2's room, V6 had shoved R2's head up, leaving her hair ruffled. V5 asked R2 and V6 if everything was okay, and V6 said yes. V5 asked R2 and stated she did not respond. V5 told V6 that R2 had ate all her breakfast. V6 told V5 he had asked two aides if R2 had eaten. V5 told V6 she was on the hall, and he must have asked the wrong aide. V5 then walked away, and stated she reported it to the first nurse she saw, which was V8. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/31/24, at 2:45 PM, V5 stated she was sitting at the nurse's station, and she heard V6 yelling angrily about her f******* neck. V5 got up to see what was going on, and as she approached the doorway, V5 witnessed V6's hand coming off R2's head and R2's body coming back from the momentum, with her hair raised up from the physical placement of his hand. V5 stated V6 was pushing R2's head up very abruptly. V5 stated when she approached the doorway, V6 looked at her and didn't say anything. V5 stated V5 immediately went into de-escalation mode. V5 told V6 that R2 had eaten all her breakfast this morning, and it had taken her a long time to do so. V5 added R2 didn't finish breakfast until 9:30 am or so. Since it was around 12:00 pm, V5 explained to V6 it hadn't been that long since R2 had eaten, and that she might not be hungry. V6 replied he had already asked two nursing assistants how she had eaten, and that they did not know. V5 stated she told V6 he had asked the wrong CNAs, since she was the CNA assigned to R2. V5 did not notice any redness on her head, but she did state it was an aggressive shove. V5 added no one should be talking to any resident like this. V5 stated V6 always yells when he talks to her, but this time his tone was out of his norm. V5 stated after this occurred, V6 stayed about an additional 20 - 30 minutes. V6 returned after he had initially left because he had left behind his phone on R2's table. V5 stated the next thing she knew, she was talking to the police officer. V5 stated she has also heard V6 talk derogatory to some of the nurses. About 3-4 months ago, V5 was walking out of the facility and V6 had said to his dog, see that white woman there - get her. V5 stated V6 is known for saying out of line things. V5 stated V1, Administrator, has not contacted her. V5 stated she did write out a statement of the incident like she was asked. V5 stated she has not spoken with any of the management directly. On 12/30/24 at 12:55 PM, V1, Administrator, stated she called the Illinois Department of Public Health (IDPH) hotline and reported the allegation of abuse against R2 by her brother, V6. V1 stated she is still investigating the allegation, and has banned V6 from the facility pending the investigation results. V1 presented a written statement by V5 dated 12/29/24. On 12/30/24 at 1:15 PM, R1 was asked if he ever heard yelling coming from R2's room. He stated R2 yells all night. When R1 was asked if he had ever heard any male voices yelling, he stated that her brother, (V6), yells all the time. R1 stated V6 will yell at R2 to take a bite and to shut the f*** up. R1 stated V6 usually visits R2 at least daily around a mealtime. R1's room is located next to R2's room, on the same side of the hallway. On 12/30/24 at 3:00 PM, V9, CNA, stated V6 has been visiting in the facility without restrictions for at least the past 3 months. V9 stated she has heard V6 yell and curse at R2 in the past, even prior to the abuse that was reported by the paramedic in April of this year. V9 stated she has not worked R2's hall for several months, so she has not recently witnessed V6 interacting with R2. V9 stated she has not issues getting R2 to eat, and she verbally cues R2 to keep her head up, and R2 complies. On 12/30/24 at 3:00 PM, V11, LPN, stated, The facility kept (V6) out of the facility for about 3-4 weeks back in the spring, when the ambulance people witnessed him abusing her, then the facility implemented supervised visits for a while. V11 stated she does not know what interventions have been in place to keep R2 safe when V6 visits, since the supervised visits stopped, and he was allowed to be anywhere throughout the building. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/20/24 at 3:21 PM, V4, MDS Coordinator, stated she has worked for the facility for about 2.5 years. V4 stated V6 is allowed to visit anywhere in the facility. V4 added there have been so many incidents with (V6). She receives reports on how V6 talks to R2 and to the staff. V6 is also known to make racial and sexual remarks to staff. V4 stated R2 has spoken with V1, facility owner, and facility lawyers. V4 stated there are no interventions in place to keep R2 safe. V4 stated the previous Administrator had left in August or September. V4 stated R2's current care plan does document the interventions that were put into place in April of this year, after R2's brother, V6, did abuse R2. These interventions document V6 can only visit through R2's window or on the phone with staff supervision. On 12/30/24 at 3:30 PM, V2, Assistant Administrator, stated the facility owner had talked to V6. V2 was unable to remember which of the owners it was. V2 stated V6 had supervised visits with R2 in the conference room, but she would have to ask an owner when these visits started and stopped. V2 stated after there had been no behaviors from V6 during the supervised visits, it was agreed to let him visit in R2's room unsupervised sometime after August. V2 was unaware the previous abuse claim from April 2024 was substantiated. On 12/30/24 at 3:40 PM, V1 was asked when V6 was allowed back in the facility. V1 stated she wasn't sure, but she thought there was a reassessment done due to R2 declining. V1 stated R2 would call out for her bubba. V1 added she would have expected the change in visit status would have been entered on the care plan. On 12/31/24 at 8:17 AM, V13, CNA stated V6 is very aggressive with R2, and he bangs his hands on R2's table. V13 stated V6 curses all the time at R2, and she heard V6 tell R2 to shut the f*** up a couple of weeks ago, and her partner V17, CNA, said she was reporting the incident to management. V13 stated she has no issues getting R2 to eat, she verbally cues her to hold her head up, and sometimes with help her lift her chin. On 12/31/24 at 9:15 PM, V14, police officer, returned call. He stated there are no reports generated from the 12/29/24 police visit to the facility. V14 checked the CAD (computer aided dispatch) program, and stated on 12/29/24 at 1:40 PM, they received a call from V1, and the reason was described as a welfare check. V14 reviewed the visiting officers' notes, which stated no crime appeared to have occurred. There were no witnesses beside the CNA, who reported the incident, and she did not observe any physical contact. The officer observed R2 while V5 was present, and did not see any signs of injur,y and attempted to talk with R2 to the best that her baseline status allowed. V14 added they had dealt with V6 in the past when he had trespassed in the facility. V1 had told police officer V6 was only allowed to drop off food at the nurse's station. V6 received a trespass warning, which involves that he is not permitted to return to the facility, or he will receive criminal charges. V14 stated he reviewed V6's record and found no criminal charges within the county, other than a few traffic citations. V14 stated V6 is hot headed and has an opinion that he will let you know about. V14 stated there was an incident on 5/4/23, which was a domestic report when he pushed the Administrator, and on 5/19/24, a battery report that V6 slapped R2's arm. States Attorney declined to file charges. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/31/24 at 9:47 AM, V2, Assistant Administrator/former facility Administrator, stated she went through her emails and texts last night, and she created a timeline of events regarding R2 and V6's issues. V2 stated the facility does not have any interdisciplinary team (IDT) notes, nor documentation in R2's chart. V2 stated she put together a soft file, with a timeline from her texts and emails, regarding enhanced visitation for R2 and V6. This documented that on 8/2/24, V6 had been calling up to the facility asking when he is allowed to come in and see his sister. Corporate team agreed to supervised visits. On 8/4/24, V6 was in the parking lot with a police officer, and it was decided V6 could have supervised visits for 2 weeks in the conference room, with V2 present for breakfast and lunch and reassess in 2 weeks. On 8/19/24, it was decided there were no issues with the supervised visits, and V6 could come back into the facility to assist R2 with feeding all meals. On 8/20/24, visits were permitted in R2's private room. On 12/31/24 at 9:53 AM, V1 stated the maintenance people came to her a couple of weeks ago and reported they witnessed V6 tell R2 to shut the f*** up. V1 stated that she did not report it. V1 just went and talked to R2 about it, and asked her how she was feeling. On 12/31/24 at 10:15 AM V15, Maintenance, stated on 12/19/24 around 1 PM, V15 and V16, maintenance, heard someone yelling very loudly. We saw (V6) was in (R2's) face screaming and telling her to 'shut the f*** up.' V15 reported this to V1. V15 stated became very clear to him that the proper steps were not going to be taken. V15 added, There are people that do their job, and those that don't. (V1) had a very laid-back attitude. I immediately told (V1), and she did not report it to the state. We care for the residents. I pulled (V6) out of (R2's) room, and took (V6) to the conference room, and told him that if I heard that again he would never come in the facility again. V15 stated he has heard V6 saying sexual and vulgar comments to staff. V15 added, (V6) makes our staff feel very uncomfortable. V16 agreed with all the statements provided by V15. On 12/31/24 at 10:37 AM, V1 reported to surveyors she was suspended, and any further questions should be directed toward V2. V1 stated she is leaving because she has been suspended for not reporting the allegation of abuse the maintenance men reported to her a couple of weeks ago about V6 verbally abusing R2. 12/31/24 10:52 AM, V2 stated she started back here in July. V2 stated V6 called nonstop, wanting to visit R2. The nurses stated R2 was not eating and crying out all the time. V2 called her boss, and her boss stated they would discuss supervise visits. In the meantime, V6 came to the facility on a Sunday (she is not sure of date but sometime in August) with a police officer demanding to come in. V2 stated she called her bosses and told them what was happening. V2 stated her bosses said to allow (V6) to visit Monday - Friday, with administration present. (V6) came to feed R2 breakfast and lunch, and was well behaved for those two weeks. (V6) then requested to visit in (R2's) room. The bosses stated to go ahead and allow him back in her room. This occurred around August 20th. No precautions were put into place other than staff were told to keep an eye on (V6)with R2 from the hallway when they passed by. On 12/31/24 at 11:00 AM, V3, Director of Nursing, stated V6 can be a problem for other people. She added staff don't like him. V3 stated at a previous survey with federal surveyors, V6 yelled and cussed when V3 had to cut the belt off R2's wheelchair tray so it would not be considered a restraint. V3 has not witnessed V6 speaking abusively to R2, but she has witnessed him talk inappropriately to the staff. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/31/24 at 11:23 AM, V17, CNA, stated she did witness V6 tell R2 to shut the f**k up a couple of weeks ago. V17 stated she did not remember the exact date. V17 stated she reported it to an agency nurse, whose name she does not recall her. This agency nurse replied that V6 does this all the time. V17 stated she has witnessed V6 cursing and yelling at R2 ongoing for a long time, and management is aware, but nothing is ever done about it. On 1/2/25 at 2:05 PM, V2 stated there has not been any investigation started regarding the verbal abuse allegations against V6 in the middle of December reported by two CNAs, V13 and V17. Abuse Policy and prevention program, dated 10/2022, documented the facility affirms the right of the residents to be free from abuse and neglect. To do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse and neglect. As part of the resident's life history on the admission assessment, comprehensive care plan and MDS assessments, staff will identify residents with increased vulnerability for abuse and neglect who have needs that might lead to conflict. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. Employees are required to report any incident, allegation, or suspicion of potential abuse, or neglect they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. The nursing staff is responsible for reporting the appearance of suspicious bruises as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor or designated individual. Following the discovery of any suspicious bruises, the nurse shall complete a full of the resident for other bruises. Accused individuals not employed by the facility will be denied unsupervised access to the residents while the investigation. If classified as an injury of unknown source, the person gathering facts will document the injury the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. The investigator will report the conclusions of the investigation in writing to the administrator within five working days of the reported incident. The final investigation report shall contain the resident information, the original allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence, facts determined during the process of the investigation, review of medical record and interview of witnesses, conclusion of the investigation based on known facts. The Immediate Jeopardy that began on 12/19/24 was removed on 1/9/2025, when the facility took the following actions to remove the immediacy: 1. The affected resident corrective actions: Residents: A. The administrator initiated the abuse investigation. B. To ensure the safety and well-being of R2, the DON (Director of nursing) completed an assessment on 12/30/24. The result of the assessment was documented in the resident's EHR (electronic health records), and the attending physician will be notified. C. The following actions were taken to prevent alleged aggressor from perpetrating additional abusive behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Visitor was banned from visitation pending investigation. b. Police were notified of incident. c. Interdisciplinary team (IDT) will review and revise R2's care plan and implement interventions to ensure R2's safety. d. The care plan review and revision were completed by the DON/MDS (minimum data set) Nurse on 1/2/25. D. All residents have the potential to be affected by the alleged deficiency. 2. Immediate Actions: Initiated on 1/7/2025. The facility took the following immediate actions to address the citations and prevent any additional residents from suffering an adverse outcome. A. Administrator and DON education. RNC/designee will provide training to administrator and DON. The training will include buy not limited to following: a. Abuse prevention. b. Allegation of abuse checklist c. Reporting abuse within required timeframe d. Completing investigation per policy and protocols e. Reporting and investigation injuries of unknown origin f. Immediate action to ensure all potential abuse allegations are identified, reported, and investigated as abuse to safeguard the residents' safety. g. Protection of residents from further abuse from alleged perpetrators. B. Staff Education - the administrator will provide training to all staff. The training will include but not limited to the following: a. Abuse prevention including identification of the Abuse Coordinator b. Reporting abuse allegations to the administrator c. Abuse investigation procedures and documentation process. d. Reporting and investigation of injuries of unknow origin e. Immediate action to ensure all potential abuse allegations are identified, reported to the administrator to safeguard the residents' safety. f. Protection of residents from further abuse from alleged perpetrator (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. The training will be started on 1/2/2025. D. All staff who are not available and/or currently on vacation will also receive the same education upon their return to work. The administrator will provide the same training. E. The facility will provide similar training to the agency staff. F. Residents were interviewed to identify if they felt safe and/or if they have experience verbal or physical abuse while living in this facility. No concerns were identified. G. Care plan meetings. The IDT will review care plans at least quarterly and as needed. H. As part of monitoring, the Administrator will monitor through facility audit tools five staff members daily for one week and then weekly x4 weeks to ensure any allegations of abuse are reported to the abuse coordinator and investigated and reported to organizations.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review, the facility failed to report an injury of unknown origin and allegations of abuse to the Administrator and Illinois Department of Public Health for 2 of 4 residents (R2, R8) reviewed for abuse in a sample of 8. Findings include: 1. R2's Face Sheet documented R2 was admitted to the facility on [DATE], with diagnoses of metabolic encephalopathy, severe protein-calories malnutrition, diabetes, dysphagia, dementia, schizoaffective bipolar disorder, wedge compression fracture of the third lumbar vertebra, severe intellectual disabilities, hyperlipidemia, rheumatoid arthritis, heart failure, osteoporosis, Down syndrome, vascular dementia, and gastroesophageal reflux disease. R2's Minimum Data Set, MDS, dated [DATE], documented R2 is severely cognitively impaired with minimal hearing deficit. She requires substantial assistance with eating and is dependent on staff for all other activities of daily living, (ADL's). R2's Care Plan, dated 12/21/24, documented R2 is at risk for abuse and neglect due to cognitive impairment and use of psychotropic medications. The Care Plan also documented, (R2) exhibits a very strong bond with (V6, R2's Family), and growing up, tough love was shown in their home to ensure (R2)'s needs were met. Interventions added include assuring resident is in a safe and secure environment. The goal is that Staff will monitor well-being of others and R2 will have zero episodes of abuse and neglect throughout next review. Interventions include that on 4/11/24 V6 visitation was suspended. On 4/19/24 V6 visitation is to occur only with window visits and phone visits supervised by staff. Also assess R2 for abuse and neglect upon admission and quarterly, assure resident that she is in a safe and secure environment with caring professionals, assure resident that she is in a safe and secure environment with caring professionals, assure resident that staff members are available to help, continue to in-service the staff about abuse and neglect, identify areas that put resident at risk, immediately report any episodes of unknown injury, abuse or change in R2's behavior for immediate intervention and review, monitor for any changes in behavior during and following V6 visits, observe the resident for signs of fear and insecurity during delivery of care. R2's progress note, dated 10/2/24 at 10:14 AM, documented, This writer was notified by CNA (Certified Nurse's Aide) that while performing morning care, she noticed a 3x3 cm bruise on pt (patient's) L (left) upper arm. CNA notified this writer. This writer evaluated the bruise of unknown origin. This writer asked pt if they were in any pain. Pt is AXO (alert and oriented) 1-2 and did not express any pain verbally nor using facial grimace with this writer apply stimuli to the area. This writer assessed pt v/s (vital signs), all v/s are WNL (within normal limits). It continues, This writer notified family and facility NP (Nurse Practitioner) of bruise of unknown origin. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Incident Report, dated 10/2/24, documented incident description: bruise of unknown origin, resident unable to give description. It continues, IDT (Interdisciplinary Team) meeting to discuss bruising to arm from 10/2/24. Resident is alert with confusion, severely cognitively impaired. Resident requires substantial to max assist with ADLs (activities of daily living) and transfers. Brother, V6, helps with resident care frequently. Incontinent of bowel and bladder. RCA (root cause analysis): bruise located to upper arm believe to be from transfer. All previously care planned interventions in place, adding monitor bruise until healed. Continue to encourage use of wheelchair. All parties agree with plan of care. Care plan reviewed and updated. On 1/2/24 at 10:02 AM, V3, Director of Nursing, stated the facility did not report R2's bruises of unknown origin that was documented on 10/2/24. V3 stated it was on R2's care plan that R2 frequently had bruising on her arms. V3 stated she did not investigate the bruises of unknown origin, and she just determined the bruises were from a transfer because of the location of the bruising. V3 stated she did not interview any employees regarding R2's bruises of unknown origin, and the facility does not have any investigation documentation of R2's bruises that were documented in her EMR (Electronic Medical Record) on 10/2/24. On 12/31/24 at 8:17 AM, V13, CNA, stated R2's brother, V6, is very aggressive with R2 and V6 bangs his hands on R2's lap tray. V13 stated V6 curses at R2 all the time and she heard V6 tell R2 to shut the f*** up a couple of weeks ago. V13 stated she did not report the incident to anyone because her partner, V17, said she was reporting the incident to management. On 12/31/24 at 11:23 AM, V17, CNA, stated she did witness R2's brother V6 tell R2 to shut the f*** up a couple of weeks ago. V17 stated she reported the incident to a nurse, but cannot recall the nurses name because she was an agency nurse. V17 stated the nurse replied, he does this all the time. V17 added she has witnessed V6 cursing and yelling at R2 ongoing for a long time, and management is aware, but nothing is ever done about it. On 12/31/24 at 9:53 AM ,V1, Administrator, was asked if the facility had any abuse investigations for R2 from a couple of weeks ago, and V1 replied, The maintenance people came to me a couple of weeks ago and reported they witnessed (V6) tell (R2) to 'shut the f*** up.' I did not report it nor investigate it. I just went and talked to (V6) about it. I should have reported it. On 12/31/24 at 10:15 AM, V15, Maintenance Director, stated, On 12/19/24 around 1 PM (V16, Maintenance Assistant), and I heard someone yelling very loudly. We saw (V6, R2's brother), was in (R2's) face screaming and telling her to 'shut the f*** up.' I reported this to (V1, Administrator), and it became very clear to me that the proper steps were not going to be taken. There are people that do their job and those that don't. (V1) had a very laid-back attitude. V15 stated he pulled V6 out of R2's room and took V6 to the conference room along with his assistant V16, and he told V6 if he ever sees that again, he (V6) will never come into the facility again. V16, Maintenance Assistant, was present during this interview, and V16 stated he also witnessed V6 screaming at R2 and telling R2 to shut the f*** up. On 12/31/24 at 10:37 AM, V1 stated, I am leaving because I have been suspended for not reporting the allegation of abuse the maintenance men reported to me a couple of weeks ago. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145717	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Columbia	253 Bradington Drive Columbia, IL 62236

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 11:20 AM, V19, Regional Director of Operations, was asked if she expects the facility to investigate bruises of unknown origin, and V19 replied, I would have to look at our policy. V19 then stated, We would expect the Administrator to report abuse. (R2's) care plan does say 'tough love', we know this individual (V6) and have talked to him several times. V2 and V19 stated they do not know if the allegation witnessed by V13 and V17 was ever reported or investigated. 2. R8's Face Sheet, undated, documented R8 has diagnoses of cerebral infarction with hemiplegia, altered mental status, epilepsy, delusional disorder, unspecified visual loss, unspecified hearing loss, anxiety disorder, and bipolar disorder. R8's MDS, dated [DATE], documented R8 is moderately cognitively impaired. The facility's initial incident report to IDPH (Illinois Department of Public Health), dated 1/8/25 at 9:00 AM, documented V25, LPN (Licensed Practical Nurse) stated he wanted moved off 400- hall. He could not work with R8 any longer. V25 stated he went to R8's room because R8 was yelling out, she asked me why V25 gave her two Imodium tablets. V25 said he informed R8 that he was not her nurse currently, and he did not give her any medication. V25 stated R8 went on to say to V25, What did you think you were doing when you rubbed your dick all over my face. V25 asked R8 why she would say that, and she repeated her statement. V25 went on to say he left R8's room and did not go back in there for the remainder of his shift. V25's emailed statement, dated 1/8/25 at 9:27 AM, documented, Went to resident's room (R8) because she was yelling out and being disruptive. When I went into this resident's room to ask why she was yelling out, she asked me why I gave her two Imodium tablets. I informed her that I was not her nurse currently and I did not give her any medication. (R8) then went on to say '(V25) what did you think you were doing when you rubbed your d*** all over my face.' I asked her why she would say that she repeated her statement, so I then left this resident's room and did not go back in there for the remainder of my shift. I reported this incident to the nursing director. On 1/9/25 at 1:40 PM, V3, Director of Nursing, stated V25 worked the night shift of 1/7/25, and V25 called her on his way home after his shift on the morning of 1/8/25 to let her know what R8 was saying about him, because V25 was upset. V3 stated V25 told her R8 was saying things that were inappropriate. V3 stated she did not ask V25 what time R8 made the allegation during his shift. V3 stated she did not think V25 immediately reported the statement by R8 because he didn't feel like he had done any abuse; he V25 felt like he was being abused. On 1/9/25 at 3:29 PM, V25 stated on Tuesday night (1/7/25) around 7-8 PM, R8 requested to see V25 and that R8 asked him why he had given her an Imodium, and that he explained to R8 that he was not her nurse. V25 stated R8 then stated to him what did you think you were doing when you put your d*** all over my face. V25 stated he felt like the victim at this time. V25 stated initially he didn't think R8's accusations appeared serious, but when R8 was continuing discussing it the next morning, he thought he should call management. V25 stated V3, DON, was not in the building when he left, so he called her on the phone somewhere between 8-9 AM on 1/8/25. On 1/13/25 at 8:53 AM, V2, Assistant Administrator, stated per the facility abuse policy, V25 should have immediately reported R8's abuse allegations to management. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse Policy and Prevention Program, dated 10/2022, documented the facility affirms the right of the residents to be free from abuse and neglect. To do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse and neglect. As part of the resident's life history on the admission assessment, comprehensive care plan and MDS assessments, staff will identify residents with increased vulnerability for abuse and neglect who have needs that might lead to conflict. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. Employees are required to report any incident, allegation, or suspicion of potential abuse, or neglect they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. The nursing staff is responsible for reporting the appearance of suspicious bruises as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor or designated individual. Following the discovery of any suspicious bruises, the nurse shall complete a full of the resident for other bruises. Accused individuals not employed by the facility will be denied unsupervised access to the residents while the investigation. If classified as an injury of unknown source, the person gathering facts will document the injury the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. The investigator will report the conclusions of the investigation in writing to the administrator within five working days of the reported incident. The final investigation report shall contain the resident information, the original allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence, facts determined during the process of the investigation, review of medical record and interview of witnesses, conclusion of the investigation based on known facts.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on interviews and record review, the facility failed to investigate allegations of verbal abuse and injury of unknown origin for one of 4 residents (R2) reviewed for investigation of abuse in the sample of 8. Findings include: R2's Face Sheet, undated, documents R2 has diagnoses of diagnoses of metabolic encephalopathy, severe protein-calories malnutrition, dementia, schizoaffective bipolar disorder, severe intellectual disabilities, Down syndrome, and vascular dementia. R2's Minimum Data Set (MDS), dated [DATE], documents resident is severely cognitively impaired with minimal hearing deficit. R2's MDS documents she requires substantial assistance with eating and is dependent on staff for all other activities of daily living (ADL's). R2's Progress noted, dated 10/2/24 at 10:23 AM, documents V20, Licensed Practical Nurse, LPN, was notified by V17, CNA, that while performing morning care, she noticed a 3x3cemtmeter (cm) bruise on R2's left upper arm. V17 notified V20 who evaluated the bruise of unknown origin. V20 asked R2 if she was in any pain. R2 is alert and oriented to person and did not express any pain verbally nor using facial grimace when V20 applied stimuli to the area. V20 notified family and facility Nurse Practitioner (NP) of bruise of unknown origin. Incident report, dated 10/2/24, documented an interdisciplinary (IDT) meeting was formed to discuss bruising to the arm. The root cause analysis (RCA) was the bruise located to the upper arm is believed to be from transfer. R2's Care Plan, dated 12/21/24, documented R2 is at risk for abuse and neglect due to cognitive impairment and use of psychotropic medications. The Care Plan also documents, (R2) exhibits a very strong bond with (V6), (R2's Family), and growing up, tough love was shown in their home to ensure (R2's) needs were met. Interventions added include assuring resident is in a safe and secure environment. The goal is that staff will monitor well-being of others and R2 will have zero episodes of abuse and neglect throughout next review. Interventions include that on 4/11/24, V6's visitation was suspended. On 4/19/24, V6 visitation is to occur only with window visits and phone visits supervised by staff. Also assess R2 for abuse and neglect upon admission and quarterly, assure resident that she is in a safe and secure environment with caring professionals, assure resident that she is in a safe and secure environment with caring professionals, assure resident that staff members are available to help, continue to in-service the staff about abuse and neglect, identify areas that put resident at risk, immediately report any episodes of unknown injury, abuse or change in R2's behavior for immediate intervention and review, monitor for any changes in behavior during and following V6 visits, observe the resident for signs of fear and insecurity during delivery of care. On 12/31/24 at 9:53 AM, V1, Administrator, stated V15, Maintenance, and V16, Maintenance, came to her a couple of weeks ago and reported they witnessed V6 tell R2 to shut the f*** up, and V1 stated she did not report it. V1 just went and talked to V6 about it, and saw that she (R2) was okay. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/31/24 at 10:15 AM, V15 stated on 12/19/24 around 1 PM, V15 and V16, heard someone yelling very loudly. V15 stated, We saw (V6) was in (R2's) face screaming and telling her to 'shut the f*** up.' V15 stated he reported this to V1. V15 stated it became very clear to him that the proper steps were not going to be taken. V15 added, There are people that do their job and those that don't. (V1) has a very laid-back attitude. V15 had immediately told V1, and she did not report it to the state. V15 stated they care for these residents. V15 stated he then pulled V6 out of R2's room and took to the conference room. He told him that if he heard him talk to her like that again, V15 would make sure V6 never come into the facility again. V15 stated he has also heard V6 saying sexual and vulgar comments to staff. V15 stated, He makes our staff feel very uncomfortable. On 12/31/24 at 8:17 AM. V13, Certified Nurse's Aide, CNA, stated R2's brother, V6, is very aggressive with R2 and V6 bangs his hands on R2's lap tray. V13 stated V6 curses at R2 all the time, and she heard V6 tell R2 to shut the f*** up a couple of weeks ago. V13 stated she did not report the incident to anyone because her partner, V17, said she was reporting the incident to management. On 12/31/24 at 11:23 AM, V17, CNA, stated she did witness V6 tell R2 to shut the f*** up a couple of weeks ago. V17 stated she reported it to an agency nurse, whose name she did not recall, and the agency nurse replied to her he does this all the time. V17 stated she has witnessed V6 cursing and yelling at R2 ongoing for a long time, and management is aware, but nothing is ever done about it. On 1/2/24 at 10:02 AM, V3, Director of Nursing, DON, stated the facility did not report R2's bruises of unknown origin that was documented on 10/2/24. V3 stated it was on R2's care plan that she frequently had bruising on her arms. V3 stated she did not investigate the bruises of unknown origin, and she just determined the bruises were from a transfer because of the location of the bruising. V3 stated she did not interview any employees regarding R2's bruises of unknown origin, and the facility does not have any investigation documentation of R2's bruises documented in her electronic medical record (EMR) from 10/2/24. On 1/2/24 at 11:20 AM, V19, Regional Director of Operations, was asked if she expects the facility to investigate bruises of unknown origin, and V19 replied I would have to look at our policy. We would expect the Administrator to report abuse. (R2's) care plan does say 'tough love'; we know this individual (V6) and have talked to him several times. V2 and V19 stated they do not know if the allegation witnessed by V13 and V17 was ever reported or investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse Policy and prevention program, date 10/2022, documented the facility affirms the right of the residents to be free from abuse and neglect. To do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse and neglect. As part of the resident's life history on the admission assessment, comprehensive care plan and MDS assessments, staff will identify residents with increased vulnerability for abuse and neglect who have needs that might lead to conflict. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. Employees are required to report any incident, allegation, or suspicion of potential abuse, or neglect they observe, hear about or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. The nursing staff is responsible for reporting the appearance of suspicious bruises as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor or designated individual. Following the discovery of any suspicious bruises, the nurse shall complete a full of the resident for other bruises. Accused individuals not employed by the facility will be denied unsupervised access to the residents while the investigation. If classified as an injury of unknown source, the person gathering facts will document the injury the location and time it was observed, any treatment given and notification of the resident's physician, responsible party. The Department of Public Health will be notified. The investigator will report the conclusions of the investigation in writing to the administrator within five working days of the reported incident. The final investigation report shall contain the resident information, the original allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence, facts determined during the process of the investigation, review of medical record and interview of witnesses, conclusion of the investigation based on known facts.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on record review and interviews, the facility failed to ensure physician visits were alternated with the Nurse Practitioner visits every 60 days after the first 90 days of admission for 4 of 4 residents (R1, R2, R6 and R7) reviewed for physicians' visits in the sample of 8. Findings include: 1.R1's Face Sheet, dated 12/31/24, documented R1 was admitted to the facility on [DATE] with diagnoses of hemiplegia, diabetes, weakness, gastroesophageal reflux disease (GERD), convulsions, depression, hemiplegia, cardiomyopathy, hypertension, and congestive heart failure. R1's Minimum Data Set, dated dated [DATE], documented R1 is cognitively alert. He uses a wheelchair for mobility due to right sided weakness. R1's Care Plan, dated 12/26/24, documented R1 is a bleeding risk, he has a self-care deficit with activities of daily living (ADLS), diabetic risk, seizure risk, skin complication risk, altered communication, heart failure risk, and fall risk. R1's electronic medical record (EMR) documented he was seen by the nurse practitioner (NP) 26 times on the following dates:1/6/24, 1/17/24, 2/1/24, 2/12/24, 2/21/24, 3/6/24, 3/20/24, 4/9/24, 4/22/24, 5/22/24, 6/11/24, 7/10/24, 7/29/24, 8/9/24, 9/4/24, 9/6/24, 9/27/24, 10/8/24, 10/9/24, 10/10/24, 10/24/24, 10/29/24, 11/12/24, 12/12/24, 12/17/24 and 1/10/25. Further review revealed he was seen by the physician, V34, only one time in the entire last year, on 3/26/24, with a physician progress note dated on that date. On 1/13/25 at 11:45 AM, R1 stated he has not seen his physician in a long time. 2. R2's admission record, dated 12/20/24, documented she was originally admitted to the facility 12/23/2017, with diagnoses of metabolic encephalopathy, severe protein-calories malnutrition, diabetes, dysphagia, dementia, schizoaffective bipolar disorder, wedge compression fracture of the third lumbar vertebra, severe intellectual disabilities, hyperlipidemia, rheumatoid arthritis, heart failure, osteoporosis, Down syndrome, vascular dementia, and GERD. R2's MDS, dated [DATE], documents resident is severely cognitively impaired, with minimal hearing deficit. She requires substantial assistance with eating and is dependent on staff for all other ADLS. She is always incontinent of urine. R2's EMR documented in the last year, she was seen by the nurse practitioner (NP) 32 times on 1/2/24, 1/10/24, 1/25/24, 1/31/24, 2/8/24, 2/16/24, 3/1/24, 3/14/24, 4/6/24, 4/12/24, 5/20/24, 5/22/24, 6/13/24, 7/2/24, 7/16/24, 7/18/24, 8/7/24, 9/5/24, 9/19/24, 9/26/24, 10/10/24m 10/15/24, 10/11/24, 11/26/24, 11/27/24, 11/29/24, 12/4/24, 12/16/24, 12/23/24, 12/28/24, 12/31/24 and 1/2/25. Further review revealed that she was seen by the physician, V35, only one time in the entire last year on 8/27/24, with a physician progress note provided with that date. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.R6's undated face sheet documented R6 was originally admitted on [DATE], with most recent admission occurring on 1/10/2024. His diagnoses include metabolic encephalopathy, morbid obesity, acute and chronic respiratory failure, chronic obstructive pulmonary disease, vascular dementia, depression, congestive heart failure, hypertension, dementia, atrial fibrillation, and lumbago. R6's MDS, dated [DATE], documented resident is severely cognitively impaired. He requires use of a wheelchair for mobility. He is always incontinent of bowel and bladder. He requires substantial assistance for toileting hygiene, showering, lower body dressing, personal hygiene and taking on and off footwear. He requires partial assistance with oral hygiene and upper body dressing. R6's Care Plan, dated 11/28/24, documented focus problems that he requires assistance with daily care needs, bleeding risk, CHF complication risk, diabetic risk, displayed sexual behaviors, elopement risk, abuse and neglect risk and fall risk. R6's electronic medical record (EMR) was reviewed, and it revealed in the last year he was seen by the Nurse Practitioner (NP) 25 times on 1/2/24, 1/4/24, 1/5/24, 1/12/24, 2/9/24, 2/16/24, 3/5/24, 4/30/24, 5/9/24, 5/20/24, 6/10/24, 7/22/24, 8/5/24, 9/2/24, 9/26/24, 10/3/24, 10/7/24, 10/8/24, 10/22/24, 11/7/24, 12/3/24, 12/27/24, 1/2/25 and 1/8/25. Further review revealed he was seen by the Physician, V31, only on 2/6/24 and 12/20/24. 4.R7 was admitted to the facility on [DATE], with diagnoses of cerebral infarction, chronic obstructive pulmonary disease, acute resp failure, difficulty in walking, multiple pelvis fractures, severe protein calorie malnutrition, atrial fibrillation, leukemia, coronary artery dissection, depression, and neuropathy. R7's MDS, dated [DATE], documented resident is cognitively intact. He requires use of a wheelchair for mobility. He requires supervision for toileting hygiene. He requires partial assistance for personal hygiene, showering, lower body dressing and applying and removing footwear. He is independent with eating, oral hygiene, and upper body dressing. He is always incontinent of urine and frequently incontinent of bowels. R7's Care Plan, dated 12/26/24, documented he requires assistance with daily care needs to weakness, risk for bleeding, fall risk, altered cardiac function risk, oxygen use at 6 liters per minute continuously, potential for breathing difficulty and skin complication risk. Most recent orders documented OT and PT clarification, pain management referral, regular diet with fortified potatoes and lunch and dinner and super cereal at breakfast. R7's electronic medical record (EMR) was reviewed, and it revealed since admission on 9/18/24, he was seen by the Nurse Practitioner (NP) sixteen times on 9/19/24, 10/1/24, 10/4/24, 10/10/24, 10/15/24, 10/18/24, 10/25/24, 11/18/24, 11/27/24, 12/5/24, 12/6/24, 12/10/24, 12/11/24, 12/16/24, 12/24/24 and 12/30/24. Further review revealed he was seen by the Physician, V31, on 09/25/24 for an admission visit with a physician progress note for that date. There was no other documentation that indicated he was seen by the physician after 09/25/24. On 1/13/25 at 11:40 AM, R7 stated it has been a long time since he has seen his physician. On 1/13/25 at 11:40 AM, V29, Nurse Practitioner, stated she has not yet heard back from V31, whom she had text earlier, regarding his expectations of frequency of staff visits. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/2025 at 9:20 AM, V2, Assistant Adminstrator, stated the current company began providing physician coverage in November 2023. V2 provided progress notes for one physician visit each for R1, R2 and R7, and two visits for R6. She stated these are the only times they have been seen by a physician since November 2023. On 1/9/25 at 12:08 PM, V1, Administrator, stated the facility does not have the physician visit documentation for the four residents requested, and the facility doesn't have anything to show how often the physician visits. On 1/13/25 at 2:15 PM, V33, Regional Director of Operations, stated he would expect the policy to be followed, and physician visits to be made every 60 days, alternating visits with the Nurse Practitioner. The facility's physician visit policy, dated 1/2010 and updated last on 7/23/24, documented each resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter. Must be seen means that the physician must make face to face contact with the resident. A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required. At the option of the physician after the initial visit, may alternate between personal visits by a nurse practitioner (NP), clinical nurse specialist or physician assistant (PA). However, the physician must visit resident when the resident's condition makes that visit necessary.