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	08/14/2024

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview, observation, and record review, the facility failed to ensure a resident was free from abuse, from a resident with a history of prior altercations, for 2 of 2 (R2 and R5) residents reviewed for abuse in the sample of 6. This resulted in R2 receiving physical harm, facial bruising, including right cheek, bridge of her nose, and below both eyes and utilizing the reasonable person concept, this failure resulted in psychosocial harm by R2 yelling out in fear Hit me one more time and I swear. Findings Include: R5's Facesheet documents an admitted [DATE]. Diagnosis include Dementia, Displaced Intertrochanteric Fracture of Right Femur, Subsequent Encounter for Routine Healing, Chronic Obstructive Pulmonary Disease, Protein Calorie Malnutrition, and Cirrhosis of the Liver. R5's Minimum Data Set (MDS), dated [DATE], documents R5 is severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. R5 requires substantial/maximum assist with transfers. Wheelchair is main mode of transportation. R5 displays little interest in doing things, has sleep issues, poor appetite, and trouble concentrating. R5's Care Plan, initiated 6/20/2023, documents R5 has a diagnosis of Dementia and may display altered cognition, change in moods/behaviors related to diagnosis. R5 often refuses to change clothing; staff assistance with care; R5 will urinate in trash cans, on the floor use blankets, clothing, and towels between her legs, near perineal area and urinate on them. R5 had a resident-to-resident altercation on 10/22/2023, 12/14/2023 and 8/1/2024. R2's Facesheet documents an admitted [DATE]. Diagnosis includes Dementia, Severe Intellectual Disabilities, Severe Protein Calorie Malnutrition, and Dysphagia. R2's MDS, dated [DATE], documents R2 is severely cognitively impaired with a BIMS score of 0, indicating severely impaired cognition. R2 requires substantial/maximum assist with transfers. Wheelchair is main mode of transportation. R2 shows little interest in activities, has sleeping issues, and poor appetite. (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 0600 Level of Harm - Actual harm Residents Affected - Few	R2's Care Plan, initiated on 7/3/2023, documents Abuse: R2 is at risk for abuse and neglect related to her cognitive and physical deficits. History of physical contact made by brother, POA (Power of Attorney). R2 exhibits a very strong bond between her and her brother. Growing up, tough love was shown in their home to ensure R2's needs were met. Resident to resident altercation on 8/1/2024. Facility incident report, dated 10/22/2023, documents R5 slapped another resident in the face in the dining room. R5 stated she slapped the other resident because the resident spit in her face. Description of incident documents this writer explained to R5 that she should not physically touch another resident or staff and if someone does something to her she should let the staff know. R5 was removed from the dining room and ate dinner by the nurse's station. No signs/symptoms of pain or discomfort. All parties notified. No injuries observed. R5's Nursing Note, dated 10/22/23 at 4:45 PM, documents, Resident observed by staff slapping another resident in the face in the dining room. This writer asked the resident why she slapped the resident in the face, and she stated that the other resident spit in her face. The resident was removed from the dining room and ate dinner at the nurse's station. This writer explained to the resident that she cannot physically touch another resident and if she has a problem let the staff know. Notified Administrator POA and NP of resident status change. No s/s (signs/symptoms) of pain or discomfort noted. The only intervention added to R5's Care Plan for this altercation was 10/22/23 Resident to resident- Psych consulted and resident to eat meals in less stimulated environment. Facility incident report, dated 12/14/2023, documents housekeeping staff member reported seeing resident kick another resident's wheelchair then push him in the wheelchair forward. When other resident didn't move, R5 slapped at his head causing his glasses and hat to fall off. Description of incident when interviewed stated R5 stated she doesn't remember hitting anyone. No injuries. R5's Nursing Note, dated 12/14/23 at 10:54 AM, documents, Resident was behind another resident both in wheelchairs she kicked the other wheelchair 3 times and pushed resident forward in wheelchair when that resident didn't move, she slapped his hat and glasses off no injury noted admin don np and POA made aware. There was no new intervention added to R5's Care Plan after this altercation. Facility incident report, dated 8/1/2024 at 8:15PM, stated V1, Administrator, notified of resident-to-resident altercation between R5 (BIMS score of 3) and R2 (BIMS score 0). V8, Certified Nursing Assistant, CNA, had walked past the room and saw R5 sitting on R2's bed with blanket over R2's head. V8, CNA, stated she did not see R5 hit R2. V8, CNA, immediately separated them, had V9, CNA, move R5 out of the room and stay with her and R2 was then placed in wheelchair and brought up to the nurse's station for the nurse to assess. R2 stated, Hit me one more time and I swear. Once R2 was up nurse's station she was her typical feisty self but not yelling out and did not have any mental anguish. Power of Attorney, POA, police, and Medical Doctor, MD, were notified. R5 was sent to local hospital where she remains today for psychiatric evaluation. Per staff interviews this is not typical behavior for R5 as she is normally pleasant, sleeps well, and likes to roll around in the hall in her wheelchair. They have not witnessed R5 yelling at R2 previously or being agitated with R2 in the past. V8, CNA, an V9, CNA, were in the room [ROOM NUMBER] minutes prior and had changed R5 and assisted her to bed. V12, Nurse Practitioner, NP, assessed R2 on 8/2/2024. R2 remains herself without any mental anguish. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The (Local Police Department's) Police Report, dated 8/1/24 at 8:22 PM, documents I reviewed the video and observed (R5) to be upset over (R2) making noise. (R5) proceeds to get up from her bed several times to repeatedly hit (R2) in her bed. (R5) also places a blanket over (R2) and begins to choke her. (R2) can be heard at various times shouting for (R5) to stop. (R2) also states at one point she can hardly breathe. The incident takes place over an approximately 10-minute period and ends only when (Facility) staff enters the room. R2's Nurses Note, dated 8/1/24 at 9:50 PM, documents, CNA alerted this nurse about resident-to-resident altercation. Head to toe assessment completed, no injuries at the moment. Management/MD/POA notified. R2's Nurses Note (Admin), dated 8/2/24 at 7:29 PM, documents, Late Entry: Note Text: Resident's roommate immediately moved off hall and sent to (Local Hospital) for psych evaluation. R2's Nurses Note, dated 8/2/24 at 7:29 PM, documents, Res (resident) has been yelling out and refusing to take her meds, res has a black eye and nose is bruised. Res has 1:1 care. Res in bed resting with call light in reach. R2's Nurses Note, dated 8/7/24 at 1:23 PM, documents, Resident has bruising to right cheek bridge of nose and below both eyes, denies pain POA here in conference room for supervised visit for lunch appetite good continues to yell out tries to stand up from wheelchair staff monitoring closely POA aware of behavior. R5's Nursing Note, dated 8/1/24 at 9:43 PM, documents, CNA alerted this nurse about resident-to-resident altercation. As the nurse entered the room, res was in the roommate's bed. Res had no injuries. Management/MD/POA notified. R5's Nursing Note, dated 8/1/24 at 9:44 PM, documents, Res sent to (Local Hospital) for psych eval. On 8/13/24 at 9:40 AM, V5, Certified Nursing Assistant (CNA), stated R2 was assaulted one evening by her roommate (R5). V5 stated R2's family has a video of R5 trying to smother R2 by putting a sheet over her head. V5 showed the bruising to R2's face, and stated it was much worse than that. They sent R5 to (Local Hospital) Psych to be evaluated. (R5) is back, but now in a different room. V5 stated the Police did show up to investigate the incident. V5 stated R5 seems with it most of the time, but she does have dementia. V5 stated if R5 would know what she did, she would be embarrassed because that is not who she is. V5 stated she does not recall having any issues with the two residents prior to that day. On 8/13/24 at 12:05 PM, V1, Administrator, stated all the rooms in the facility are full and they do not have a private room to put R2 in. V1 stated the hospital told her R2 did not have any behaviors while she was in the hospital. V1 was not aware of any other incidents regarding R5 and her aggressive behaviors. When V1 was advised of the other resident-to-resident altercations, V1 stated there are 114 residents in the facility at this time, with two in the hospital. V1 stated she can't put R5 on the 300-hall due to R2 being there. V1 stated one of the residents in the hospital had a private room, so she will move R5 to that room immediately. On 8/13/24 at 12:45 PM, V7, CNA Supervisor, stated R5 is a one-on-one at this time since she returned, and they are sitting with R5 and monitoring her behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/13/24 at 3:25 PM, V11, R5's Sister, stated, I am (R5's) sister and POA (Power of Attorney). I visit her about three times a week. They put (R2) in the room with (R5) and all she does is yell out. Who would be able to tolerate that, it wasn't a good thing. Both have dementia so that made it even worse. I watched the video of what happened between (R2) and (R5) and it was horrible. It's a good thing that it didn't end up even worse. I couldn't believe (R5) was doing that. They have her in a private room now with a sitter, so that should help. I am trying to get her into a facility that will take care of someone like her. V11 asked R5 if she remembers why she got so mad at her roommate (R2), and R5 said I don't know. On 8/13/24 at 3:30 PM, V13, CNA (Certified Nursing Assistant), was assigned to be a one-on-one with R5. V13 stated she has worked with R5 for a long time and could not believe she did something like that. V13 stated that is not like her. On 8/14/24 at 11:20 AM, V1, Administrator, stated, We don't have a copy of the video that was on (R2's) brother's phone. He did show me the video and yes, that is what happened. (R5) was sitting on (R2's) bed and had a sheet or blanket on (R2's) head. On 8/14/24 at 11:55 AM, V15, R2's Brother/POA, stated he does not have his cell phone with him, and his daughter deleted the video they had about the incident. V15 stated he saw R5 sitting on R2's bed with her back toward the camera, and she had a sheet or blanket that she was holding over R2. On 8/14/24 at 2:15 PM, R6 stated, I like having a roommate. If I had a roommate that tried to hit me or did hit me, I would run for help. I am not a violent person, and that would scare me. I would never want that to happen. Facility abuse policy, dated 10/2022, states, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order 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, neglect, exploitation of property, deprivation of goods and services by staff and mistreatment of residents.