

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Bria of Elmwood Park		STREET ADDRESS, CITY, STATE, ZIP CODE 7733 West Grand Avenue Elmwood Park, IL 60707	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to notify the attending physician of an acute change in condition to include loose stools and weakness. This affected one of three residents (R1) reviewed for notification of a change.</p> <p>The findings include:</p> <p>Ambulance record dated [DATE] documents called to location for patient in cardiac arrest. RN says this patient was last checked on by CNA around 2:00AM, however she had come on at 11:00PM and not seen this patient. Patient is pale cold to the touch. Patient is laying in fluids that have dried to the linens. Crew takes over compressions and places patient on monitor. Rhythm check confirms asystole and no pulse. Crew removes CPR board and notes the patient's neck remains in position without being held. Crew notes severe stiffness to the mandible and neck. Crew contact hospital and received orders to terminate resuscitation. Reason rescue stopped: Obvious signs of death.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:02AM, V16, Certified Nursing Assistant (CNA), said I started at 3:00PM on Sunday [DATE] and remained until 7:00AM on [DATE]. V16 said I started with rounds around 11:00PM. V16 said I saw R1 he was sleeping, I did not wake him up. V16 said R1 is usually sleeping on night shift and he had his eyes closed. V16 said on night shift R1 is incontinent of urine and bowel and I check his diaper. V16 said I checked R1 between 1:00AM and 2:00AM he had diarrhea, he was not talking too much, I changed his diaper. V16 said that is his usual not talking. V16 said I pushed him to help roll him and R1 grabbed the side rail while I changed him. V16 said that day it was new for him to have diarrhea. V16 said R1 had diarrhea twice on ,d+[DATE] shift and I told V17, RN. V16 said V17 said she would look for Imodium. V16 said R1 had diarrhea after dinner, around 8:00PM. V16 said R1 ate a little, he said he didn't want to eat. He drank ok, he drank ice water he drank half of it. V16 said R1 only drank half the ice water for both shifts. V16 said R1 didn't say anything to me about the diarrhea. V16 said then around 1:00AM R1 had diarrhea and I cleaned him. V16 said R1 seemed weak maybe from the diarrhea. V16 said I asked the nurse, V3, for Imodium and she said R1 did not have an order for Imodium. V16 said at 4:00AM R1 was not responding I called the nurse. V16 said when I entered R1's room, he was not responding I ran to the nurse, I said check him he looks like he is not breathing. V16 said I shook R1 on his shoulder and arm. R1 had a facility gown on, he was on his back and had a pillow under his head. V16 said the bed was slightly elevated. V16 said R1 had a bowel movement at that time that is why I was checking him. Nurse started pumping his chest, we called 911. We called a code blue. V16 said the ambulance did not take R1 from the facility. V16 said I and the other CNA cleaned him. He had diarrhea on the pad, it was all water at that time. V16 said on ,d+[DATE] shift the stool was all water and on ,d+[DATE] shift the stool was still water.</p> <p>On [DATE] at 11:55AM V3, Licensed Practical Nurse, said around 4:00AM I was called by the CNA and when I entered the room R1 wasn't breathing, he was cold, and had no pulse. V3 said this was the first time I saw R1. V3 said when I got report, I asked the nurse if there is anyone I need to lookout for, and the nurse said no. I was not aware that anything was going on with R1.</p> <p>On [DATE] at 12:41PM V6, Paramedic, said we were called to the facility for cardiac arrest. V6 said when we arrived, we started advanced life support. V6 said when we were starting to intubate R1 was sitting up a little, from the shoulder up. V6 said we started to connect R1 to the Cardiopulmonary Resuscitation (CPR) machine we saw R1 had early stages of rigor mortis. V6 said R1's jaw and neck and everything was stiff. V6 said we couldn't move R1's mouth without his whole head moving. V6 said R1 was beyond help at that time. V6 said we asked the staff when they checked R1 and they (facility staff) had no time line of when they were last checked on. V6 said we (EMS team) could tell R1 has been deceased for a little while. V6 said when I touched R1 he was ice cold, cold to the touch. V6 said I saw R1's upper body from the nipples up was stiff, his jaw had rigor mortis, his eyes were fixed and dilated, he was asystole on the monitor, and his mouth was open. V6 said the cloth bed chuck under R1 had dry ring on it and the pad was dry he had been sitting on it a while. V6 said the pad had feces and urine, the ring was a light brown, there was an odor possibly feces odor. V6 read the narrative sheet and said the narrative says the nurse said she had not seen the patient her shift. He should not be past help.</p> <p>On [DATE] at 11:26AM V17, RN, said on Sunday ,d+[DATE]:00PM shift I didn't have any reports of patients with watery diarrhea. I don't know who V16 is. V17 said if a resident is having frequent stool or diarrhea, I would call the doctor and get an order for a stool sample. V17 said I would check the stool, check vitals, temperature, check for hemorrhoids, listen to and palpate the abdomen. V17 said I would document the call and assessment. V17 said I would need an order for Imodium and to give any medication to a resident.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 2:25 PM, V8, Director of Nursing, said CNAs and nurses to do rounds every ,d+[DATE] hours. V8 said if the resident is sleeping the staff are expected to check them, make sure the call light is in reach, they are awake, and offer assistance. V8 said for reports of diarrhea or loose/watery stools the nurse should assess the resident, offer as needed medication if available. If the condition is new the nurse should notify the Nurse Practitioner or Doctor and follow orders. V8 said the Nurse Practitioner or Doctor should be made aware if loose stools continue into 2 shifts. On follow up interview on [DATE] at 2:07PM, V8 said the Nurses should do rounds on residents every ,d+[DATE] hours. V8 said the expectation for the nurse, including night shift, is for first rounds should be done within the first hour. The surveyor asked V8 what are the risk of untreated loose stools in a patient? V8 said dehydration is the highest risk. V8 said hydration can be done by IV in the facility. The RN can start a peripheral IV and the contracted companies can be called for a hard stick.</p> <p>On [DATE] at 12:09PM, V42 Doctor, said at the onset of new diarrhea I expect they should let me or the NP know if it occurs. I would order a c-diff test and possibly labs, especially in a nursing home patients. I would expect to be notified of loose stools if occur ,d+[DATE] times especially if not resolving. I would expect the nurse to have assessed the patient for symptoms, any pain, and how does the patient present and report it. Diarrhea is loose or watery stools with ,d+[DATE] bouts of it. I don't recall being notified of R1 having loose stools. I don't recall R1 having Chronic loose stools.</p> <p>R1's diagnosis include but are not limited to Osteomyelitis, Adjustment Disorder, Anemia, Hypertension, Hypotension, Lymphedema, Stage Four Pressure Ulcer, and Adult Failure to Thrive.</p> <p>Review of R1's Medication Review Report includes orders from [DATE] until [DATE] has no order for as needed anti diarrhea medication. R1's Order Summary Report reviewed and no order for as needed anti diarrhea medication.</p> <p>R1's care plan reviewed which includes focus on non-compliance, aggression, cognition, need for assistance with activities of daily living including needing assistance for incontinence of bowel and bladder, and bowel constipation. R1's care plan has no care plan for diarrhea.</p> <p>Review of R1's Medication Administration Record for [DATE] shows no as needed medication to treat diarrhea was given or added to the record from [DATE]-[DATE]. Vitals are documented completed but no values (blood pressure, temperature, pulse, or respirations were provided when requested.</p> <p>Review of R1's Progress Notes from [DATE] thru [DATE]. There is no documentation that a physician was notified of R1 having loose stools. There is no documentation of a nursing assessment related to R1 having loose stools.</p> <p>Review of the facility policy Change in Resident Condition dated ,d+[DATE] states: It is the policy of the facility, except in medical emergency, to alert the resident, resident's physician and responsible party of a change in condition. 1. Nursing will notify the resident's physician or nurse practitioner when: there is a significant change in the resident's physical, mental, or emotional status. Once the physician has been notified and a plan developed the nursing or social service staff will alert the resident and family of the issue and any physician orders. Communication will be documented in the medical record. The care plan will be updated as appropriate.</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796</p> <p>Based on interview and record review the facility failed to prevent an incident of staff to resident mental abuse. This affected one of three residents (R5) reviewed for mental abuse. This resulted in V9 (Activity Aide) pulling a wig off R5's head after a disagreement. R5 said she felt humiliated and embarrassed.</p> <p>Findings include:</p> <p>R5's MDS dated [DATE] denotes BIMS score of 15.</p> <p>On 8/6/24 at 2:20 pm, R5 observed alert and oriented to person, place, and time and situation. R5 said that V9 (Activity Aide) snatched her wig off. R5 said V9 was upset because she (R5) had borrowed a portable speaker from a friend that V9 wanted to borrow. R5 said V9 told her (R5) that she (R5) was selfish and an inconsiderate person for borrowing the speaker. R5 said this happened in the hall and there was staff in the area. R5 said her and V9 exchanged words, R5 said V9 said to her (R5) to go get some teeth and R5 responded by saying go get a body, you're shaped like sponge [NAME], R5 said V9 then said I will pull your wig off, R5 responded by saying what wig, not this this wig, well do it then, and V9 snatched her (R5) wig off. R5 said she then threw a cup at V9 and grabbed V9 shirt. R5 said she was embarrassed that V9 pulled her wig off her head, R5 said she doesn't have hair, just a few strings of hair. R5 said V9 knows her (R5) family and she thought V9 was like family, but no one in her family would have ever pulled her wig off her head.</p> <p>R5's statement gathered during facility investigation denotes in-part, R5 stated that V9 pulled her (R5) wig off and it embarrassed her (R5).</p> <p>8/6/24 at 3:26 pm, V7 (Administrator) said she interviewed the nurse that was on duty when the incident occurred with R5 and V9. V7 read the statement from the nurse denoting that R5 told the nurse that V9 pulled her wig off. V7 said, V9's actions were not willful. V7 said, the nurse stated that she (V37) doesn't think the activity aide had ill intent. V7 was asked, how can the nurse speak for a resident that is alert and oriented, who stated that she was embarrassed by V9's actions.</p> <p>V37's (Nurse) interview from facility investigation denotes in-part V37 said she heard commotion and when she turned around R5 was throwing cups at V9. V37 immediately went to separate R5 and V9 because R5 had a hold of V9's shirt and did not let want to let go. V37 stated that R5 did not want to let go of V9's shirt because R5 stated V9 pulled her wig off. V37 stated that V38 from therapy came out of the therapy room and was able to get R5 to let go of V9's shirt. V37 (Nurse) denies seeing V9 pull off R5's wig. V37 states, that what she did witness she did not feel like V9 was intentionally trying to hurt R5 in anyway.</p> <p>On 8/9/24 at 4:09 pm, V38 (Occupational Therapist) said he heard the commotion, he observed V9 and R5 arguing, R5 grabbed V9. V38 said he separated V9 and R5 and left the facility for the day.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Abuse prevention policy dated 2/2017 denotes in-part this facility affirms the right to our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property or mistreatment by anyone but not limited to facility staff, other residents, consultants, volunteer, staff from other agencies providing services to the individual, family members or legal guardian, friends, or any other individuals.</p> <p>The Resident's Rights for the people living in the long-term care facilities denotes in-part your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796</p> <p>Based on interview and record review the facility failed to ensure that all healthcare personnel have current basic life support cardiopulmonary resuscitation training and certification. Ten certified Nursing Aides 10 of 10 (V27, V28, V29, V30, V31, V32, V33, V34, V35, V36) reviewed for current CPR.</p> <p>Findings include:</p> <p>[DATE] at 1:39 pm, V7 (Administrator) said the facility does not require that all the Certified Nursing Assistants have a cardiopulmonary resuscitation training and certification, she only encourages the aides to have the training.</p> <p>V11 (Human Resource Staff) presented a list of Certified Nursing Aides that do not have current CPR certification and are currently working at the facility. V11 said all the certified nursing aides do not need to be CPR trained.</p> <p>[DATE] at 2:13 pm, V8 (Director of Nursing) said some of the aides that currently work at the facility do not have CPR training and certification. V8 said they do not have to have CPR training and certification. Facility CPR policy reviewed with V8 denoting that it is all staff responsibility to perform CPR. V8 said if an aide finds a resident unresponsive, they should go and inform a nurse.</p> <p>V27, V28, V29, V30, V31, V32, V33, V34, V35, V36 names are listed as the CNA staff that do not currently have CPR cards. Date of hire range from [DATE] to [DATE].</p> <p>Facility policy titled Cardiopulmonary Resuscitation dated 2015 presented by V7 denotes that cardiopulmonary resuscitation in attempt to restore breathing respiration and the heartbeat pulse by compressing the chest and or artificially breathing for a person based on American Heart Association current guidelines. Level of responsibility ALL STAFF.</p> <p>The facility policy denotes that all staff is responsible to perform CPR, however per V7 (Administrator) the certified nursing aides are not required to have CPR certification. Using a reasonable person concept, it is reasonable to believe that the CNA that do not have CPR training will not be able to perform CPR according to the American Heart Association during a situation where a resident is found without a pulse and or without respirations.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to conduct a comprehensive assessment of one resident who developed new loose stools. This affected one of three residents (R1) reviewed for quality of nursing care and assessments. This failure resulted in R1's loose stools being left untreated.</p> <p>The findings include:</p> <p>Ambulance record dated [DATE] documents called to location for patient in cardiac arrest. RN says this patient was last checked on by CNA around 2:00AM, however she had come on at 11:00PM and not seen this patient. Patient is pale cold to the touch. Patient is laying in fluids that have dried to the linens.</p> <p>On [DATE] at 11:02 AM, V16 Certified Nursing Assistant (CNA), said I started at 3:00 PM on Sunday [DATE] and remained until 7:00 AM on [DATE]. V16 said I started with rounds around 11:00 PM. V16 said I saw R1 he was sleeping, I did not wake him up. V16 said R1 is usually sleeping on night shift and he had his eyes closed. V16 said on night shift R1 is incontinent of urine and bowel and I check his diaper. V16 said I checked R1 between 1:00 AM and 2:00 AM he had diarrhea, he was not talking too much, I changed his diaper. V16 said that is his usual not talking. V16 said I pushed him to help roll him and R1 grabbed the side rail while I changed him. V16 said that day it was new for him to have diarrhea. V16 said R1 had diarrhea twice on ,d+[DATE] shift and I told V17, RN. V16 said V17 said she would look for Imodium. V16 said R1 had diarrhea after dinner, around 8:00 PM. V16 said R1 ate a little, he said he didn't want to eat. He drank ok, he drank ice water he drank half of it. V16 said R1 only drank half the ice water for both shifts. V16 said R1 didn't say anything to me about the diarrhea. V16 said then around 1:00 AM R1 had diarrhea and I cleaned him. V16 said R1 seemed weak maybe from the diarrhea. V16 said I asked the nurse, V3, for Imodium and she said R1 did not have an order for Imodium. V16 said at 4:00 AM R1 was not responding I called the nurse. V16 said when I entered R1's room, he was not responding I ran to the nurse, I said check him he looks like he is not breathing. V16 said I shook R1 on his shoulder and arm. R1 had a facility gown on, he was on his back and had a pillow under his head. V16 said the bed was slightly elevated. V16 said R1 had a bowel movement at that time that is why I was checking him. Nurse started pumping his chest, we called 911. We called a code blue. V16 said the ambulance did not take R1 from the facility. V16 said, me and the other CNA cleaned him. He had diarrhea on the pad, it was all water at that time. V16 said on ,d+[DATE] shift the stool was all water and on ,d+[DATE] shift the stool was still water.</p> <p>On [DATE] at 11:55 AM, V3 Licensed Practical Nurse, said around 4:00 AM I was called by the CNA and when I entered the room R1 wasn't breathing, he was cold, and had no pulse. V3 said this was the first time I saw R1. V3 said when I got report, I asked the nurse if there is anyone I need to lookout for, and the nurse said no. I was not aware that anything was going on with R1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 12:41 PM, V6 Paramedic, said we were called to the facility for cardiac arrest. V6 said when we arrived, we started advanced life support. V6 said we asked the staff when they checked R1 and they (facility staff) had no time line of when they were last checked on. V6 said we (EMS team) could tell R1 has been deceased for a little while. V6 said when I touched R1 he was ice cold, cold to the touch. V6 said I saw R1's upper body from the nipples up was stiff, his jaw had rigor mortis, his eyes were fixed and dilated, he was asystole on the monitor, and his mouth was open. V6 said the cloth bed chuck under R1 had dry ring on it and the pad was dry he had been sitting on it a while. V6 said the pad had feces and urine, the ring was a light brown, there was an odor possibly feces odor. V6 read the narrative sheet and said the narrative says the nurse said she had not seen the patient her shift.</p> <p>On [DATE] at 11:26 AM, V17 RN, said on Sunday ,d+[DATE]:00 PM shift I didn't have any reports of patients with watery diarrhea. I don't know who V16 is. V17 said if a resident is having frequent stool or diarrhea, I would call the doctor and get an order for a stool sample. V17 said I would check the stool, check vitals, temperature, check for hemorrhoids, listen to and palpate the abdomen. V17 said I would document the call and assessment. V17 said I would need an order for lmodium and to give any medication to a resident.</p> <p>On [DATE] at 2:25 PM, V8 Director of Nursing, said CNAs and nurses to do rounds every ,d+[DATE] hours. V8 said if the resident is sleeping the staff are expected to check them, make sure the call light is in reach, if they are awake, offer assistance. V8 said for reports of diarrhea or loose/watery stools the nurse should assess the resident, offer as needed medication if available. If the condition is new the nurse should notify the Nurse Practitioner or Doctor and follow orders. V8 said the Nurse Practitioner or Doctor should be made aware if loose stools continue into 2 shifts. On follow up interview on [DATE] at 2:07 PM, V8 said the Nurses should do rounds on residents every ,d+[DATE] hours. V8 said the expectation for the nurse, including night shift, is for first rounds should be done within the first hour. The surveyor asked V8 what are the risk of untreated loose stools in a patient? V8 said dehydration is the highest risk. V8 said hydration can be done by IV in the facility. The RN can start a peripheral IV and the contracted companies can be called for a hard stick.</p> <p>On [DATE] at 12:09 PM, V42 Doctor, said if a patient develops loose stools or diarrhea, would expect the nurse to have assessed the patient for symptoms, any pain, and how does the patient present and report it. Diarrhea is loose or watery stools with ,d+[DATE] bouts of it. I don't recall being notified of R1 having loose stools. I don't recall R1 having Chronic loose stools.</p> <p>R1's diagnosis include but are not limited to Osteomyelitis, Adjustment Disorder, Anemia, Hypertension, Hypotension, Lymphedema, Stage Four Pressure Ulcer, and Adult Failure to Thrive.</p> <p>Review of R1's Medication Review Report includes orders from [DATE] until [DATE] has no order for as needed anti diarrhea medication. R1's Order Summary Report reviewed and no order for as needed anti diarrhea medication.</p> <p>R1's care plan reviewed which includes focus on non-compliance, aggression, cognition, need for assistance with activities of daily living including needing assistance for incontinence of bowel and bladder, and bowel constipation. R1's care plan has no care plan for diarrhea.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's Medication Administration Record for [DATE] shows no as needed medication to treat diarrhea was given or added to the record from [DATE]-[DATE]. Vitals are documented completed but no values (blood pressure, temperature, pulse, or respirations were provided when requested.</p> <p>Review of R1's Progress Notes from [DATE] thru [DATE]. There is no documentation that a physician was notified of R1 having loose stools. There is no documentation of a nursing assessment related to R1 having loose stools. There is no record that R1 refused assessment from the nurses on [DATE].</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER Bria of Elmwood Park		STREET ADDRESS, CITY, STATE, ZIP CODE 7733 West Grand Avenue Elmwood Park, IL 60707	
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)		
<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>38796</p> <p>Based on observation, interview, and record review the facility failed to have a licensed respiratory therapist on duty on 8/8/24 for the entire duration of the shift. This affected 11 of 11 residents (R13-R23) reviewed for respiratory care.</p> <p>Findings include:</p> <p>On 8/8/24 at 6:40 am, V19 (Respiratory Aide/respiratory therapy student) was observed going from resident room to resident room, administering respiratory care and treatments, working unsupervised by a licensed respiratory therapist on the trach/vent unit. V19 said the Licensed Respiratory Therapist left at 6:30 am, V19 said he always leaves early. V19 said she was a student, and she does not graduate school until December 2024. R13-R23 was assigned to V19 on 8-8-24.</p> <p>On 8/9/24 at 9:59 am, V25 (Respiratory Therapy Supervisor/ Director) said respiratory therapy students should not be working alone, unsupervised, and they should be working with a licensed respiratory therapist. V25 said she was not aware that V25 was working without a licensed therapist. V25 said she was not aware that the licensed therapist left early. V25 said there should be two respiratory therapists on the trach/ vent unit. V25 said the respiratory student can conduct the same task as the licensed respiratory therapists if the student has received the competency and are comfortable in the skill set. V25 said the licensed respiratory therapist must be on the unit to check the work behind the respiratory student.</p> <p>During this survey the facility failed to present policy/procedures/protocol for respiratory assistance/ respiratory therapy student.</p> <p>Facility assignment sheet denotes V39 and V19 are the respiratory therapist assigned to the 7:00pm-7:00am shift of 8/7/24. V39 time card reviewed, denoted V39 punched out at 6:35am on 8/8/24.</p> <p>Facility assessment tool with review date 1/8/2024 presented by V7 (Administrator) denotes the facility require 2 respiratory therapists for the 7:00pm to 7:00am shift. The facility assessments tool does not denote information regarding respiratory therapy assistance/ respiratory therapy students.</p> <p>The Professions, occupations, and business operations, (225 ILCS 106/) Respiratory Care Practice Act describes Proximate supervision means a situation in which an individual is responsible for directing the actions of another individual in the facility and is physically close enough to be readily available, if needed, by the supervised individual.</p>		