

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  11/22/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38796</p> <p>Based on interview and record review the facility failed to ensure a resident recieved the correct dose of medication as prescribed, Oxycodone 5 milligrams every eight hours as needed. This affected one of three residents (R1) reviewed for professional standards of care for medication administration.</p> <p>Findings include:</p> <p>On 11/21/24 at 8:15am, R1 observed alert to person, place, time and situation. R1 said his pain is being managed. R1 said he doesn't take Oxycodone 5 mg like that, R1 said he doesn't take Oxycodone every four hours. R1 said he takes other medications to reduce his pain also. R1 said he might take Oxycodone 5 mg after returning to the facility from being out on pass, R1 said when he's out on pass he's moving around more and that increases his pain. R1 said he last took Oxycodone last night (11/20) when he returned to the facility. R1 said he went out on pass on Monday 11/18/24, R1 said it was later in the day. R1 said he does not know what time he requested Oxycodone 5 milligrams on Monday 11/18/24.</p> <p>Review of facility resident sign out log with V2 (Social Services Director), V2 said he reviewed the record with R1 and R1 identified his signatures and R1 said on 11/18/24 R1 went out on pass at 3:40pm and returned at or around 7:00 ish before 8:00pm. R1 was not in the facility at 4:50pm (time of signed out oxycodone on 11/18/24). V2 said he verified with the front desk staff that the front desk staff wrote R1's name in areas on the resident sign out log by initials that were R1's initials.</p> <p>Review of R1 controlled drug log for Oxycodone 5 mg. V1 signed out Oxycodone for R1 at 4:50pm on 11/18/24. V2 said R1 was not in the facility at 4:50pm.</p> <p>Review of R1 control drug receipt/record/ distribution form for Oxycodone tab 5 mg (milligrams), directions denote in part take one tablet by mouth every 8 hours as needed DX (diagnosis) pain in bilateral legs. Every dose must be accounted for and requires charting on the medication administration record. Oxycodone 5 mg was signed out on 11/13/24 at 7:00am, 11/13/24 at 11:30am, 11/13/24 at 4:00pm, 11/13/24 at 8:00pm, 11/14/24 at 9:00am, 11/15/24 at 8:00am, 11/17/24 at 8:00am, 11/17/24 at 2:32pm, 11/18/24 at 1:00am, 11/18/24 at 8:00am, 11/18/24 at 12:30pm, 11/18/24 at 4:50pm, 11/19/24 at 7:45pm, 11/20/24 at 9:00am and 11/20/24 at 7:00pm.</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 0658</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 there are no documented initials by the Nurse, denoting administration for Oxycodone 5 mg on 11/13/24 at 7:00am, 11/13/24 at 11:30am, 11/13/24 at 4:00pm, 11/13/24 at 8:00pm, 11/14/24 at 9:00am, 11/15/24 at 8:00am, 11/17/24 at 8:00am, 11/17/24 at 2:32pm, 11/18/24 at 1:00am, 11/18/24 at 8:00am, 11/18/24 at 12:30pm, 11/18/24 at 4:50pm, 11/19/24 at 7:45pm, 11/20/24 at 9:00am and 11/20/24 at 7:00pm.</p> <p>R1 physician order sheet shows orders for Oxycodone HCl oral tablets 5 mg (milligrams), give one tablet by mouth every 8 hours as needed for Dx; pain bilateral legs. Order date 11/12/24.</p> <p>On 11/21/24 at 11:00am, request was made to V3 (Director of Nursing) to review documentation for administration of Oxycodone 5mg for R1 from 11/13/24 to 11/21/24. V3 (Director of Nursing) said she has in-serviced her staff on documenting control substance. V3 said her expectation is that the Nurse assess the resident complaints of pain, document the complaints of pain, sign out the control substance on the control drug log and sign out the medication when it is administered on the medication administration record. V3 said the Nurse should sign out the medication immediately after administering the medication to the resident. V3 failed to present documentation denoting R1 was administrated Oxycodone 5 mg from 11/13/24 through 11/21/24 (with exceptions to 11/16/24 at 5:28, and 11/19/24 at 6:12am).</p> <p>Upon exit of this survey the facility failed to present documentation denoting R1 was administrated Oxycodone 5 mg from 11/13/24 through 11/21/24 (with exceptions to 11/16/24 at 5:28, and 11/19/24 at 6:12am). Upon exiting this survey, the facility failed to present documentation denoting that R1 was sent out on pass with narcotics on 11/18/24 at 4:50pm.</p> <p>On 11/21/24 at 9:15am V1 (LPN) said she administered Oxycodone 5 mg to R1 without reviewing the medication administration record and physician orders. V1 said she administered oxycodone 5 mg to R1 every four hours. V1 said the order was for every 8 hours. V1 said she did not review the physician orders, nor did she review the medication administration record when removing the narcotic from the lock box, and when she signed the narcotic out on the control drug log. V1 said she realized she was administering Oxycodone 5 milligrams to R1 in error last week. V1 said she had not reported this medication error to V3 (Director of Nursing).</p> <p>Facility policy titled Narcotic Medications with last review date of 1/2024 denotes in part to provide guidelines for handing, distribution, and destruction of narcotics. The following medication are classified as narcotic, oxycodone. When a narcotic medication is administered it should be signed out in the individual Narcotic sign out record and documented. If a resident goes out on pass, narcotic may be sent with corresponding order. Document what was sent.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38796</p> <p>Based on interview and record review the facility failed to follow their narcotic medication policy to ensure control medication Oxycodone 5 milligrams are documented and accounted for. This affected one of three resident (R1) reviewed for controlled medications.</p> <p>Findings include:</p> <p>On 11/21/24 at 8:15am, R1 observed alert to person, place, time and situation. R1 said his pain is being managed. R1 said he doesn't take Oxycodone 5 mg like that, R1 said he doesn't take Oxycodone every four hours. R1 said he takes other medications to reduce his pain also. R1 said he might take Oxycodone 5 mg after returning to the facility from being out on pass, R1 said when he's out on pass he's moving around more and that increases his pain. R1 said he last took Oxycodone last night (11/20) when he returned to the facility. R1 said he went out on pass on Monday 11/18/24, R1 said it was later in the day. R1 said he does not know what time he requested Oxycodone 5 milligrams on Monday 11/18/24.</p> <p>Review of facility resident sign out log with V2 (Social Services Director), V2 said he reviewed the record with R1 and R1 identified his signatures and R1 said on 11/18/24 R1 went out on pass at 3:40pm and returned at or around 7:00 ish before 8:00pm. R1 was not in the facility at 4:50pm (time of signed out oxycodone on 11/18/24). V2 said he verified with the front desk staff that the front desk staff wrote R1's name in areas on the resident sign out log by initials that were R1's initials.</p> <p>Review of R1's controlled drug log for Oxycodone 5 mg. V1 (Licensed Practical Nurse) signed out Oxycodone for R1 at 4:50pm on 11/18/24. R1 was not in the facility at 4:50pm.</p> <p>Review of R1's control drug receipt/record/ distribution form for Oxycodone tab 5 mg (milligrams), directions denote in part take one tablet by mouth every 8 hours as needed DX (diagnosis) pain in bilateral legs. Every dose must be accounted for and requires charting on the medication administration record. Oxycodone 5 mg was signed out on 11/13/24 at 7:00am, 11/13/24 at 11:30am, 11/13/24 at 4:00pm, 11/13/24 at 8:00pm, 11/14/24 at 9:00am, 11/15/24 at 8:00am, 11/17/24 at 8:00am, 11/17/24 at 2:32pm, 11/18/24 at 1:00am, 11/18/24 at 8:00am, 11/18/24 at 12:30pm, 11/18/24 at 4:50pm, 11/19/24 at 7:45pm, 11/20/24 at 9:00am and 11/20/24 at 7:00pm.</p> <p>Review of R1 medication administration record there are no documented initials by the Nurse, denoting administration for Oxycodone 5 mg on 11/13/24 at 7:00am, 11/13/24 at 11:30am, 11/13/24 at 4:00pm, 11/13/24 at 8:00pm, 11/14/24 at 9:00am, 11/15/24 at 8:00am, 11/15/24 at 8:00am, 11/17/24 at 8:00am, 11/17/24 at 2:32pm, 11/18/24 at 1:00am, 11/18/24 at 8:00am, 11/18/24 at 12:30pm, 11/18/24 at 4:50pm, 11/19/24 at 7:45pm, 11/20/24 at 9:00am and 11/20/24 at 7:00pm.</p> <p>R1 physician order sheet shows orders for Oxycodone HCl oral tablets 5 mg (milligrams), give one tablet by mouth every 8 hours as needed for Dx; pain bilateral legs. Order date 11/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/24 at 11:00am, request was made to V3 (Director of Nursing) to review documentation for administration of Oxycodone 5mg for R1 from 11/13/24 to 11/21/24. V3 (Director of Nursing) said she has in-serviced her staff on documenting control substance. V3 said her expectation is that the Nurse assess the resident with complaints of pain, document the complaints of pain, sign out the control substance on the control drug log and sign out the medication when it is administered on the medication administration record, V3 said the Nurse should document the response to the pain medication also. V3 said the Nurse should sign out the medication immediately after administering the medication to the resident. V3 failed to present documentation denoting R1 was administrated Oxycodone 5 mg from 11/13/24 through 11/21/24 (with exceptions to 11/16/24 at 5:28, and 11/19/24 at 6:12am).</p> <p>Upon exit of this survey the facility failed to present documentation denoting R1 was administrated Oxycodone 5 mg from 11/13/24 through 11/21/24 (with exceptions to 11/16/24 at 5:28, and 11/19/24 at 6:12am). Upon exiting this survey, the facility failed to present documentation denoting that R1 was sent out on pass with narcotics on 11/18/24 at 4:50pm.</p> <p>On 11/21/24 at 9:15am V1 (LPN) said she administered Oxycodone 5 mg to R1 without reviewing the medication administration record and physician orders. V1 said she administered Oxycodone 5 mg to R1 every four hours. V1 said the order was for every 8 hours. V1 said she did not review the physician orders, nor did she review the medication administration record when removing the narcotic from the lock box, and when she signed the narcotic out on the control drug log. V1 said she realized she was administering Oxycodone 5 milligrams to R1 in error last week. V1 said she had not reported this medication error to V3 (Director of Nursing).</p> <p>Facility policy titled Narcotic Medications with last review date of 1/2024 denotes in part to provide guidelines for handing, distribution, and destruction of narcotics. The following medication are classified as narcotic, oxycodone. When a narcotic medication is administered it should be signed out in the individual Narcotic sign out record and documented. If a resident goes out on pass, narcotic may be sent with corresponding order. Document what was sent.</p>		