STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145419	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Elmwood Park	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)
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** 45000 Based on interview and record review, the facility failed to report allegations of physical abuse for one (R1) resident out of three residents reviewed for physical abuse. Findings include: On 12/14/2024, at 10:03AM, R1 states there was an altercation that took place, and he was sent out to the hospital. R1 states he told another resident to turn their television/TV down and then the other resident attacked him. R1 states he does not know the other residents' name and forgot which room number the incident occurred in. R1 states himself and the other resident were not roommates. R1 states he was inside of his own room, which was separate from the other residents' room. R1 states he went to the other residents' room to tell him to turn the TV down and the other resident attacked him from the back. R1 then states the event occurred so long ago that he can't remember what happened and maybe the other resident was his former roommate. R1 states he is unable to describe the resident who attacked him but states he is a white male. R1 states the white male attacked him from behind and was trying to choke him. R1 states there were no witnesses to the incident that occurred. R1 states he was hospitalized for one day and returned to the facility. Record review documents that R1 and R3 were former roommates who resided in the same room on 11/15/2024. On 12/14/2024, at 10:29AM, R3 states he had two former roommates (identified as R1 and R4) residing with him in the same room on 11/15/2024. R3 states on 11/15/2024, R4 was watching TV inside of their shared room. R3 states R1 told R4 to turn his TV down and R1 got upset. R3 states R4 is elderly and uses a wheelchair for ambulation. R3 states R1 became upset and proceeded to start charging towards R4 while R4 was sitting in his wheelchair. R3 states R1 was about to attack R4 but R3 intervened by grabbing R1 and holding R1 back. R3 states he had R1 in a bear hug holding him down until staff entered the room. R3 states if he had not stopped R1, R1 would have hit R4. R3 states staff came inside of their room and separated them. R3 states he told the staff everything that happened and R1 was sent out to the hospital. R3 states he never attacked or choked R1 and R1 is a trouble maker who has a history of starting stuff. R3 states R1 returned from the hospital and the facility moved R1s' room down the hall. R3 states R4 was discharged home and no longer resides in the facility. Record review documents that R4 resided in the same room as R1 and R3 on 11/15/2024. R4 was discharged home from the facility on 11/22/2024. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/2024, at 12:59 PM, V7 (Social Service Director/SSD) states he is aware of the altercation that took place between R1 and R3. V7 states R1 and R3 were former roommates who had an argument because R1 thought R3s' TV was too loud. V7 states R3 did not want to turn his TV down so the facility made a room change. V7 states during the time of the altercation, R1 was not redirectable so R1 was sent out to the hospital via involuntary petition so that R1 can have a psychiatric evaluation. V7 states the facility has a hospital contact person (identified as V8) who is employed at the veterans' hospital. V7 states he contacts V8 whenever anything happens that involve veteran residents. V7 states R1 and R3 are both veterans so he informed V8 about the altercation involving R1 and R3. V7 states he was made aware by V8 that when R1 went to the hospital, R1 informed V8 that R3 had choked R1. V7 states he was made by V8 via email regarding allegations of R3 choking R1. V7 states he performed an investigation and asked other staff members who worked that day about the allegations. V7 states he also interviewed R1, R3, and R4. V7 states R4 told him that R1 was the one with verbal aggression. V7 states he informed V8 that the facility reported the allegations to the state agency. V7 states he informed his administrator (identified as V1) about the allegations made by R1. V7 states V1 (Administrator) told him to start an investigation and he did. V7 states V1 is the person who submitted the initial and final report to the state agency. Record review documents that V6 (Registered Nurse/RN) was the nurse assigned to care for R1 and R3 on 11/15/2024. On 12/14/2024, at 1:36PM, V6 (Registered Nurse/RN) states R1 and R3 were former roommates, and she was the nurse assigned to care for both of them on 11/15/2024. V6 states she did not witness the altercation between R1 and R3. V6 states she was coming back from break and remembers seeing R3 sitting in the lobby, and she inquired why. V6 states other staff members were present and handling the situation with R1 and R3. V6 states R3 informed her that R1 threatened R3 so R3 felt the need to defend himself. V6 states R3 informed her that R3 put R1 in a choke hold/head lock. V6 states she did not get a chance to get an account of R1s' story. V6 states the facility was in the process of sending R1 out to the hospital to be evaluated. V6 states R1 has never reported to her that R3 abused R1. V6 states she is trained on abuse and knows who to report abuse to. V6 is able to verbalize different types of abuse. V6 states she knows to report abuse if she witnesses abuse or if it is reported to her. Facility reported incidents dated 10/04/2024 to 11/26/2024 were reviewed. There is no file/folder or documentation to show that the facility reported allegations of abuse to the state agency for R1 and R3. Surveyor made V7 aware of this. On 12/14/2024, at 2:28 PM, V7 (SSD) states he is unaware of where the entire folder/documentation is, which shows proof that the facility submitted/reported allegations of abuse related to R1 and R3. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/14/2024, at 2:06 PM, V5 (Licensed Practical Nurse/LPN) states she was not the nurse assigned to care for R1 and R3 on 11/15/2024, but she did work on that day. V5 states she saw R3 siting in the lobby and she was told that R1 and R3 were in an altercation. V5 states she did not witness the altercation between R1 and R3. V5 states R1 told her that R3 attacked him from behind and hit him in the head. V5 states R1 told her that R1 doesn't want R3 anywhere near R1. V5 states R1 told her that his altercation with R3 was due to the TV being too loud. V5 states someone in the social services department asked her what happened but she can't remember who questioned her. V5 states she believes she filled out a form stating what happened, but she can't be sure. V5 states to her knowledge, R1 does not have a history of aggression and R1 and his new roommate have not had any altercations. V5 states to her knowledge, R3 also does not have a history of aggression. Record review documents that R1 and R3 resided on the first floor of the facility on 11/15/2024. Review of the facility nursing staff schedule documents that V12, V13, V14, and V15 were all assigned to work on the first floor of the facility on 11/15/1014. On 12/14/2024 at 2:55PM, an attempt to contact V12 (Certified Nursing Assistant/CNA) was made, no answer, left voice message, awaiting call back. On 12/14/2024 at 2:57PM, an attempt to contact V13 (Certified Nursing Assistant/CNA) was made, no answer, left voice message, awaiting call back. On 12/14/2024 at 2:58PM, an attempt to contact V14 (Certified Nursing Assistant/CNA) was made, no answer, left voice message, awaiting call back. On 12/14/2024, at 3:00PM, V15 (CNA) states she was the CNA assigned to care for R1 and R3 on 11/15/2024. V15 states she was on her lunch break and upon returning to the facility, V15 was informed by staff that there was an altercation between R1 and R3. V15 states she did not witness the altercation between R1 and R3 and was not made aware of any abuse allegations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/15/2024, at 10:36AM, V1 (Administrator) states has been the abuse coordinator at the facility since 09/2024. V1 states he was out of state from 11/14/2024 to 11/19/2024 and returned back to work at the facility on 11/20/2024. V1 states when he returned to work, he was made aware by V7 (SSD) that V8 (Veteran Hospital Staff) shared concerns of an altercation related to R1 and R3. V1 states V7 is the person who started the investigation and submitted the initial report to the state agency. V1 states he does not remember any names of the staff or residents that were interviewed during the process of investigations. V1 states V7 also completed and submitted a final report and submitted it to the state agency. V1 states if he does not initiate an abuse report, then he does not complete a final abuse report since he is not the one who initiated it. V1 states the protocol for resident-to-resident abuse allegations are as follows: separate residents and ensure they are safe, perform 1:1 observation, send a resident out to the hospital if warranted, notify the doctor and the family, initiate an investigation, interview staff and residents and obtain statements, then determine a conclusion. V1 states the facility initially report allegations of abuse to the state agency as soon as possible or within 2 hours. V1 states another final report is submitted to the state agency within 5 days. V1 states the facility only use fax communication to submit reportable documents to the state agency. V1 states though the process of investigating, R1s' abuse allegations were unfounded. Surveyor inquires to V1 about documentation of proof of an investigation and proof of submitting a report to the state agency for R1s' allegations. V1 states unfortunately, he is unable to find the folder containing those documents. V1 then states to surveyor that he was informed that surveyor was given the initial abuse report as proof. Surveyor makes V1 aware that there is no documentation to show that the initial report was faxed/submitted to the state agency. Surveyor then shows V1 the initial abuse report that was provided to surveyor by V7 (SSD) on 12/14/2024. V1 observes the initial abuse report and is made aware that there is no fax confirmation and no date to show proof of when/if the abuse report was submitted to the state agency. V1 states the initial report that V7 (SSD) provided to surveyor was saved and printed from V1s' computer. R1s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R1 has a BIMS/Brief Interview for Mental Status of 9/15, indicating R1 is cognitively impaired. R1s' care plan documents that R1 is care planned for aggression, problems with leisure activities, ADL self-care deficit, risk for falls, and risk for seizures. R3s' MDS/Minimum Data Set, dated dated dated [DATE], documents that R3 has a BIMS/Brief Interview for Mental Status of 14/15, indicating R3 is cognitively intact. R3s' care plan documents that R3 is care planned for schizoaffective disorder, psychotropic medication, identified offender, problems with leisure activities, ADL self-care deficit, and risk for falls. Social service progress note dated 11/15/2024, documents, R1 went out involuntary petition due to using inappropriate language. Family and MD/medical doctor notified; IDT/interdisciplinary team aware. Writer to provide ongoing support. Facility policy dated 10/2022, titled Abuse Policy and Prevention Program documents in part, V. Internal Reporting Requirements and Identification of Allegation: Any allegations of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.