

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 09/04/2025
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
---	-------	-----------

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 09/04/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent multiple fall incidents for a resident assessed to be high risk for fall. Facility also failed to follow proper post fall procedure and transferred resident back to bed who complained of right leg pain upon ROM (Range of Motion) assessment. This deficient practice affects one resident (R1) of three residents reviewed for fall incidents. R1 was sent out to the hospital and admitted with Right Closed Hip Fracture. Findings Include: R1 is a [AGE] year-old female resident with diagnoses of but not limited to: Muscle Weakness, Abnormal Posture, Depression, Profound Intellectual Disabilities, Seizure, Atherosclerotic Heart Disease, Dementia without Behavioral Disturbance, Anemia, Anxiety, and Generalized Osteoarthritis. admitted in the facility on 4/12/2010. R1 had a fall incident on 3/25/25 and 7/5/25. Fall incident Report dated 3/25/25, reads in part: R1 observed by staff member to be on the floor next to her bed on her left side. When the writer entered the room, R1 was lying on the floor, noted a bump in a small cut over left eye. Nurse Practitioner in the building and notified of incident with orders to send to local hospital via 911. R1 returned the same day to the facility with no major findings from the hospital. Care plan reviewed and noted 3 interventions added for this fall (3/25/25): Promote placement of call light within reach and assess residents' ability to use; encouraged to use call light for any assistance needed; Therapy to evaluate and treat. On 9/3/25 at 11:00AM, V2 (Director of Nursing) stated that the IDT (Interdisciplinary Team) meet and analyze the root cause of the fall. The intervention then will be added on resident plan of care based on the root cause. V2 stated they are unable to identify the root cause and call light intervention was added on 3/25/25. V2 also stated V2 does not know the reason why call light intervention was added and that the fall incident did not mention anything about the call light concerns related to this fall incident. Facility Reported Incident to IDPH, final report dated 7/11/25, reads in part: fall date incident 7/5/25. CNA observed R1 lying on the floor. The CNA informed the nurse. The doors immediately performed a head-to-toe assessment and noticed facial grimace and R1 would not extend the right leg. The nurse informed telehealth and was ordered to medicate to send out for further evaluation. Conclusion: the nurse had medicated R1 and left the room. The nurse noticed the door was closed. The nurse preceded to open the door and noticed R1 on the floor lying in the dorsal position. The nurse immediately assessed the resident. Nurse performs range of motion on all extremities, R1 could that extend right leg and in doing so the residents had facial grimaces. R1 is nonverbal and cannot recall what happened. Nurse called the physician and was ordered to send out for x-ray and pain management. Pain medication given and transported to local hospital for evaluation. Progress Note reviewed and dated 7/6/25: R1 admitted in the hospital with closed right hip fracture. Care plan interventions added for this fall (7/5/25) was Floor mat and therapy to evaluate and treat. On 9/2/25 at 1040AM, V3 (CNA) assigned to R1. Stated that V3 observed R1 on the floor next to her bed during her round right before dinner. V3 stated that the last time she saw the resident was during the beginning of V3's shift. V3 stated that V3 provided incontinent care during this time. V3 stated that R1 was calm, not in distress when V3 left the room. V3 stated she placed the bed in lowest position as always. Does not recall if the side rails were in use at the time. Assisted in transferring back the resident to bed using Hoyer lift. On 9/2/25 at 11:40AM, V4 (Nurse) assigned to R1. Stated that V4 was doing medication pass when the V3 informed V4 of the incident. Stated that the last time V4 saw R1 was during medication administration to R1 approximately 4pm to 5pm. That R1 was not in distress, calm and in the center of the bed. Bed in low position. V4 stated that after the report of the unwitnessed fall, V4 immediately checked on the resident. Check the surroundings to see if anything might have hit R1's head during the fall. No sign of head injury but stated that during the assessment R1 was making facial grimace when right leg was moved and right leg does not look right. V4 called the physician and ordered to send R1 out for further evaluation and to medicate for pain management. V4 stated that R1 was placed back to bed with 3 persons assist using a blanket. On 9/3/25 at 9:05AM, V7 (Restorative Nurse) stated that R1 requires substantial/maximal assistance, which requires more than half of staff effort. R1 needs guidance in holding and placing hand to side rail to reposition herself. IDT met and analyzed the root cause. It was unwitnessed and maybe R1 was not reposition in the bed right, or R1 was closer to the edge of the bed and rolled off the bed onto the floor. On 9/3/25 at 9:20AM, V2 (Director of Nursing) stated that R1 was observed by the CNA on the floor next to her bed. No floor mat at the time, floor mat was added as one of the interventions after this fall incident (7/5/25). Nurse assessed R1 and head to toes and ROM (Range of</p>		