

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 12/01/2025
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to follow policy procedures, failed to document a grievance form, failed to investigate reported theft of funds, and failed to report a theft allegation to IDPH (Illinois Department of Public Health) for one of three residents (R4) reviewed for misappropriation of funds. Findings include: On 9/26/25, IDPH (Illinois Department of Public Health) received allegations that roughly \$500 of R4's SNAP (Supplemental Nutrition Assistance Program) benefits were stolen. The complainant feels it had to have been facility staff who had access to R4's social security number. The issue was reported but nothing was done by the facility. R4 was admitted to the facility on [DATE]. On 11/20/25 at 10:38am, surveyor inquired about R4's stolen SNAP benefits V5 (Social Service Director) stated, She (R4) reported it to me (V5) over a year ago when she first admitted, it did not happen here (facility). Surveyor inquired what was implemented when the allegation was received. V5 responded, I (V5) told her (R4) we (staff) cannot help her with getting the money back. I told her to call the link card and see what they could do. She used to be with a roommate where she used to live (prior to admission) that had access to her (R4) card because it got shipped to her (roommate) address. Surveyor inquired where this information came from. V5 stated, She's (R4) the one that told me (V5). On 11/20/25 at 2:15pm, R4 stated When I (R4) first got here (facility) I had SNAP benefits saved up and because I was brought here (facility), they (staff) changed my address from my friend's house to this place (referring to facility). SNAP said they sent two letters, but the facility didn't give me those letters. What I was told when I called their (SNAP) number, is you can only order a new SNAP card if they have your social security number - the facility has access. They (unknown facility staff) stole \$500 of benefits I had. (V5) said he (V5) investigated it, but I don't believe he did anything with it. Surveyor inquired if R4's roommate (prior to admission) had access to her snap benefit card (per V5's statement) R4 responded, No, my friend never had my card. My friend I was living with never would have done that, if that's what they're (staff) claiming. I'm (R4) upset about that. The card was used in Chicago, she (friend) lived in [NAME] at the time. Surveyor inquired when the stolen SNAP benefits were reported to V5. R4 affirmed it was in February. R4's (2/11/25) progress note affirms (roughly 6 weeks after admission) resident requested SS (Social Service) to discuss her link card. She wanted her card replaced; writer gave DHS (Department of Human Services) number to call. On 11/25/25 at 1:13pm, surveyor inquired about the facility policy for reported missing items and/or funds. V5 (SSD) stated, We (staff) go talk to the resident and do a grievance form. If its money we go to the Administrator. Surveyor inquired (again) what was implemented when R4 reported stolen SNAP benefits. V5 responded, I told my Administrator about that one because that's funds, that's money. Surveyor requested R4's (February 2025) grievance form at this time however it was not received. Surveyor inquired if IDPH was notified of R4's stolen SNAP benefits. V2 (DON) affirmed that she would check with V1 (Administrator). On 11/25/25 at 1:23pm, V2 (DON) stated, I (V2) asked (V1/Administrator) if he did a reportable for missing snap benefits for her (R4), he (V1) said no. On 12/1/25 at 2:07pm, surveyor inquired about the facility policy for reported theft of funds. V1 (Administrator) stated, If someone reported missing funds, we (staff) would have to do an investigation and report it, to IDPH. Surveyor inquired if R4's alleged stolen SNAP benefits was (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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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigated. V1 responded, The way it was explained at the time was that she (R4) wasn't a resident when they were missing and when she moved in here (facility) her (R4) benefits would have been canceled. So, no we (facility) did not report it because the way it was explained is that it happened prior to moving in the building. Surveyor inquired why R4's theft allegation was not reported to IDPH. V1 responded, Again, what was reported to me (V1) is 1) her (R4) benefits would have stopped already when she was admitted here and 2) it was reported that this happened prior to coming here. Surveyor inquired if V1 spoke with R4 about the stolen SNAP benefits. V1 replied, No, I was going on the information that was brought to me that this was something that happened prior to being a resident here. Considering reasonable person concept, R4's (2/11/25) progress note, and resident/staff statements the facility was made aware of R4's link card concerns/theft of SNAP benefits - reported roughly 6 weeks after admission (not when she first admitted - as alleged). The facility abuse prevention policy (reviewed 9/2017) includes misappropriation of resident property: the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Reports will be documented and a record kept of the documentation. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall notify Department of Public Health's regional office immediately by telephone or fax. The results of the investigation will be forwarded to the Illinois Department of Public Health within seven working days of the reported incident. The administrator or designee is also responsible for informing the resident or their representative of the results of the investigation and of any corrective action taken.		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow policy procedures, failed to implement care plan interventions, failed to obtain vital signs, failed to conduct a thorough assessment, failed to fill out an SBAR (Situation Background Assessment Recommendation) form, and failed to ensure that EMS (Emergency Medical Services) was made aware of resident status/vital signs prior to arrival for one of three residents (R2) reviewed for change in condition. These failures contributed to R2's [DATE] death. Findings include: On [DATE], IDPH (Illinois Department of Public Health) received allegations that EMS was dispatched for sick, later upgraded to trouble breathing not recent - (R2's) feet were blue. (R2) was on oxygen, staff had little to no knowledge but said it was only a few minutes, it clearly had been longer that no one checked on R2 - not handled quick enough. R2 was [AGE] years old with diagnoses which include but not limited to COPD (Chronic Obstructive Pulmonary Disease), hypertensive heart disease with heart failure and peripheral vascular disease. R2's ([DATE]) care plan states resident has potential for difficulty in breathing related to COPD, intervention: observe for changes in breathing pattern. Monitor vital signs and lung sounds. R2's Physician Order Sheets include ([DATE]) Oxygen at 2 liters per minute per nasal cannula to maintain oxygen saturation readings between 90-96%. Oxygen saturation every shift for monitoring oxygen saturation readings. R2's ([DATE]) Medication Administration Record affirms oxygen saturation ranged from 95-98%. R2's progress notes include ([DATE]) 10:35pm, writer observed resident breathing heavy checked oxygen 81%, nasal cannula was applied resident oxygen level raised to 91%. 911 was called and resident was transported to Hospital. Doctor was informed [liters of oxygen, respirations, blood pressure, pulse, temperature and lung sounds were excluded]. ([DATE]) Called and spoke to Nurse who stated that resident was intubated in ambulance by paramedics and is being admitted in Intensive Care Unit with shortness of breath, hypotensive, and is being given hypertensive medicines. ([DATE]) Contacted the hospital to inquire about resident status. Nurse informed that resident expired yesterday at 9:02am. On [DATE] at 1:11pm, surveyor inquired about R2's ([DATE]) change in condition V7 (Licensed Practical Nurse) stated I (V7) normally have her (R2) and I always check on my residents. She's (R2) always taking her nasal cannula off, when I walked in it was off and her breathing wasn't normal, she was breathing heavy. I put her nasal cannula on, and her oxygen level was low it was 91%. I don't know how long the cannula was off and didn't like the way she was breathing so I got an order from the doctor to send her out 911. Surveyor inquired how many liters of oxygen R2 was placed on prior to transfer V7 responded I'm not even gonna guess I don't remember. Surveyor inquired how many liters of oxygen R2 was supposed to be on (per physician order) V7 affirmed she did not know. Surveyor inquired if R2's vital signs were obtained prior to transfer V7 replied, The EMS I think they (EMS) did obtain her vital signs when they came, I can't remember. I'm pretty sure I did them because I have to give EMS the vital signs but again my nursing action was just send her out. Surveyor inquired where R2's vital signs were documented V7 stated They would be documented in the Nurses notes. Surveyor inquired if R2's vital signs may have been documented elsewhere V7 responded I'm not for certain, I can't recall. I just reacted and called 911. Surveyor inquired if R2's feet were blue prior to transfer V7 replied, I looked at her whole body, and her feet wasn't blue. Surveyor inquired if R2 was breathing prior to EMS transfer V7 stated Yes, she was. Surveyor inquired if EMS requested R2's status upon arrival. V7 responded, I think they (EMS) asked me if she has COPD, but they didn't ask me anything else. R2's ([DATE]) vital signs documentation affirms at 1:40pm, blood pressure was 108/62, temperature was 97.8, pulse was 60, and respirations were 18. At 7:59pm, R2's oxygen saturation was 98%. No additional vital signs were documented (R2's change in condition occurred at 10:35pm). On [DATE] at 1:50pm, surveyor inquired about staff requirements for resident change in condition. V2 (Director of Nursing) stated, They (staff) need to do an assessment and notify the doctor. Surveyor inquired what an assessment entails. V2 responded, A (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	head to toe assessment and vitals. Surveyor inquired where resident vital signs are documented. V2 replied, In the chart. Surveyor inquired if V7 charted R2's vital signs on ([DATE]) V2 stated I'm not really sure I do have to go back into the notes to see. V2 subsequently reviewed R2's ([DATE]) progress note and responded, Not in this note, she (V7) didn't have any vital signs in this particular note (except oxygen saturation). Surveyor inquired how many minutes it usually takes for EMS to arrive to the facility when 911 is called V2 replied It take em a couple of minutes to come here between 5 and 10 minutes they come rolling up. Surveyor inquired if V7 filled out an SBAR (which provides a structured framework for healthcare professionals to quickly and clearly share critical information about a patient, especially during handoffs) for R2's ([DATE]) change in condition V2 stated I (V2) didn't see one. Surveyor inquired if an SBAR is supposed to be filled out for resident change in condition V2 responded Yes, it is. On [DATE] at 11:13am, surveyor inquired about facility staff requirements for resident change in condition. V8 (Medical Director) stated, I would expect them (staff) to get vitals and then contact the provider. Surveyor inquired which vital signs should be obtained for a resident experiencing respiratory distress. V8 responded, The oxygen saturation, heart rate, blood pressure, all of them. Surveyor inquired if a resident is in respiratory distress which assessments should be conducted V8 replied I would expect them to see if they're alert, diaphoretic, are they struggling using accessory muscles, listen to their lungs to see if they have wheezing, crackles, or no sounds at all. Surveyor inquired about potential harm to a resident if staff fail to obtain vital signs, fail to conduct a physical assessment and/or fail to report actual changes in condition to EMS and/or healthcare provider. V8 stated, I guess increased mortality and morbidity. R1's Certificate of Death affirms death occurred on [DATE]. The ([DATE]) facility change in resident condition policy states 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 [Physical Assessment, Vital Signs, and SBAR are excluded]. The facility Respiratory Care Monitoring policy (revised 10/2024) states any change in the resident's condition will be identified such as difficulty breathing, changes in color, change in mental status, or other changes that my signal further evaluation is needed. If the change requires immediate intervention (resident is in distress, having difficulty breathing) the assessment will be completed and appropriate interventions implemented.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff report/document maintenance issues/broken equipment, and failed to ensure that broken equipment was not in use. These failures have the potential to affect 169 residents. Findings include: The 11/19/25 census includes 169 residents. On 9/26/25, IDPH (Illinois Department of Public Health) received the following allegations: A shower chair broke on 9/21 and nobody repaired, replaced, or otherwise prevented R4 from using it on 9/23 resulting in it breaking on R4. R5 entered the bathroom while R4 was showering. R4's progress notes state (9/18/25) Writer was called to shower room by staff. Writer noted the resident in the shower room on the floor. Resident lost balance while attempting to transfer to shower chair and fell to the floor. (9/24/25) Resident told writer she would like to file a complaint against another resident because she felt violated when (R5) entered the community bathroom while she was in the shower room despite her telling (R5) not to enter the bathroom. On 11/19/24 at 2:36pm, surveyor inquired if R5 entered the bathroom while R4 was showering V2 (Director of Nursing) replied, It's a stall for the bathroom and there's a shower in the back, but she (R4) doesn't want anybody in there at all, it's a community bathroom on the floor. I (V2) explained to her (R4) it's a separate stall, but she still doesn't want anybody in there. I told the CNAS (Certified Nursing Assistants) she wants to be in there by herself just kind of monitor while she's in there - if she's (CNA) available. Surveyor inquired if R4 used a shower chair that broke V2 stated, I can't remember what happened. The chair's not there anymore, I think it was broke and she was too tall. R4 resides on the 4th floor. On 11/20/25 at 1:57pm, the 4th floor (North) tub/shower room door was noted to be open, and the metal strike plate was dangling from the door. Surveyor inquired if the tub/shower rooms are supposed to be locked. V6 (CNA) stated, They used to have a lock, and they (unknown) took em off. Surveyor inquired how privacy is maintained on a male & female unit if the door doesn't lock. V6 responded, When I'm (V6) here I (V6) always close the curtain and if someone knock, I tell them go somewhere else. On 11/20/25 at 2:15pm, surveyor inquired about facility concerns R4 stated, Someone who's a lot heavier than the (shower) chair sat on it and it broke, it was really cracked. Apparently several CNAS (Certified Nursing Assistants) knew it and didn't remove it. I (R4) sat on it and just fell on the floor. Surveyor inquired how R4 knew that staff were aware of the broken chair. R4 responded, People (staff) literally said it right in front of my face. I had a person (R5) walk in on me (R4) multiple times their (staff) excuse is that she (R5) has dementia and I've been told it's a communal shower. It's happened twice now, I said I'm in here (shower room) don't come in and she (R5) says I have to go to the bathroom and just comes in. There's no lock cause it's a safety hazard. On 12/1/25 at 12:03pm, surveyor inquired about the facility protocol for broken equipment. V11 (Maintenance Director) stated, The normal protocol is that we would receive a work order to replace, repair or remove. You either call reception or write the work order in the book at the nurse's station. We (maintenance) check the work orders Monday through Friday and I'm on call. 24/7 if there's an issue. Surveyor inquired if there was a broken shower chair on 4th floor. V11 responded, We (maintenance) found out about it on the weekend and on the following Monday we replaced it. Somebody brought it downstairs. They (staff) thought it was cracked but we (maintenance) didn't know about it until it broke, the leg was cracked. This was in September. Surveyor inquired if the shower chair was broken prior to (R4) using it. V11 responded, Supposedly it was cracked and they (staff) didn't say anything to us (maintenance) until it broke, it was a failure in communication. Surveyor inquired if the shower/tub rooms are locked. V11 replied, They have locks, so people just don't go there on their own at night. Surveyor relayed that the 4th floor shower/tub room door doesn't lock (identified 11 days ago) V11 stated, This is the first I'm hearing of it. On 12/1/25 at 12:17pm, V11 inspected the (4th floor) North tub/shower door (as requested) and affirmed it did not latch when the door was closed. V11 subsequently inspected the door and stated Somebody flipped this around, this is the wrong way. Somebody put the throw on wrong. I will have that fixed today. On 12/1/25 at (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	approximately 12:30pm, V11 stated that the facility does not have a policy for maintaining equipment therefore surveyor requested the facility maintenance policy. The (10/2024) facility preventive maintenance plan states proof of inspections will be record in the electronic system or on paper trackers provided. Monthly inspections: check door contacts. Surveyor requested documentation of facility door inspections on 12/1/25 however V11 affirmed that only the fire doors are inspected, documentation was not received.		