

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  12/11/2025
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 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.  (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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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow their discharge policy and Against Medical Advice (AMA) policy when discharging a resident. This failure affected one resident (R4) of three residents reviewed for discharge. R4 was discharged from the facility to an unknown location and the facility does not know resident's current location or condition. Findings include: R4 is [AGE] years old admitted to the facility on [DATE], face sheet listed the following medical diagnosis among others: Localization-related (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable with status epilepticus, dysphagia unspecified, generalized abdominal pain, prolonged grief disorder, anxiety disorder, unspecified psychosis not due to substance or known physiological condition, depression, acute pancreatitis without necrosis or infection, alcohol use unspecified with withdrawal, uncomplicated, etc. On 12/08/2025 at 10:36AM and 1:01PM, surveyor attempted to contact resident at the number provided and left call back messages with no return call. On 12/08/2025 at 3:13PM, contacted resident's friend (V10) who said that the last time he heard from resident was a couple of weeks ago, V10 thinks he is okay, but not sure, V10 does not have any contact information for resident. He added that resident told him that he was kicked out of the facility, V10 said that he is not sure if resident got his personal items from the facility. Another attempt to contact resident was made on 12/09/2025 at 12:19PM and 1:59PM with no success. Community survival skills evaluation dated 3/28/2025 documented that resident can access the community independently. [NAME] Data Set (MDS) assessment dated [DATE], section C (cognitive) scored resident with a brief interview for mental status (BIMs) score of 15, indicating cognitively intact. Section GG (functional) indicated that resident requires staff supervision or touching assistance for all activities of daily living (ADL) needs. Section Q (participation in assessment and goal setting) of the same assessment indicated that resident is interested in living and receiving services in the community, but no referral or contact has been made, and there is no active discharge planning in progress for resident to return to the community. Progress note dated 10/6/2025 by V11 (RN) states the following: The resident requested a pass to leave the facility, stating an intention to disregard community restrictions despite prior advisories. Upon inquiry, the resident was reminded by the RN of the current access restrictions due to not adhering to curfew rules. Despite being informed, the resident stated, I don't care if they put me out, I'm leaving. Consequently, residents' belongings were packed and securely sent to storage. Both the administration and MD were notified and made aware of the situation for further action and decision-making regarding the resident's care and status. On 12/08/2025 at 1:49PM, V4 (SSD) said that R4 left against medical advice (AMA), he signed the AMA form, his pass was restricted because he was not following the rules. Surveyor requested a copy of the signed AMA form from V4, and he said that he could not find one, the resident refused to sign. Discharge policy revised 9/2017 states in part: To establish a plan of how to discharge a resident from the facility to home, another facility or the hospital. Guideline for against medical advice states: educate patient and patient's family on the risk of leaving the facility without a physician order. Notify the patient's physician, allowing the physician time to educate the patient and patient's family on the risk of leaving the facility. If the patient still insists on leaving the facility against medical advice, have the patient and patient's responsible party sign the release of responsibility for discharge form. Document in the electronic medical record (EMR) the education, physician notification and the discharge information. Scan the signed release of responsibility for discharge form into EMR. There is no documentation in medical record that the medical doctor or anyone in administration attempted to educate the resident on the dangers of going against medical advice (AMA). On 12/08/2025 at 3:12PM, V11 (RN) said that R4 wanted a pass, and it was refused due his pass privileges being revoked. R4 left the building around 8:21pm, did not take his evening medications, did not leave with any medication or his belongings, resident took his backpack, the rest of his belongings were packed and sent to storage. V11 was asked if the resident signed the AMA form and she said that resident refused, V11 did not complete an AMA form documenting resident's refusal, her signature, or the signature of any witnesses. On 12/10/2025 at 9:49AM V5 (Social Services Coordinator) said that she is familiar with R4, he does not want to be at the facility, he wants to go out, has a community pass but the day he left AMA, he wanted a pass and no one was available to give him one, residents usually get the pass from the nurse or social services but they were all busy that day. V5 said that R4 has been going out before 8:00AM, the policy is 8:00AM to 8:00PM. Surveyor asked V5 if residents can leave the facility without someone letting them out and she said that no</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to follow standard infection prevention and control regarding hand hygiene and use of gloves during care for two residents (R12 and R13) in the sample reviewed for infection control. As a result, R12 ADLs (Activities of Daily Living) bed bath was done with staff assistance with gloved hands not performing any hand hygiene or removing soiled gloves and touching R13 belongings and the clean linen cart with soiled gloves. This failure affected R12, R13 and has the potential to affect all 37-residents residing on the 1st floor. Findings include: R12's admission Record documented that R12 was admitted to the facility on [DATE] with listed diagnosis information that includes but not limited to Urinary tract infection site unspecified, other lack of coordination, type 2 diabetes mellitus without complications, muscle weakness, unspecified abnormalities of gait and mobility, peripheral vascular disease, pressure induced deep tissue damage of right ankle, pressure induced deep tissue damage of right heel, pressure ulcer of sacral region unstageable, pressure ulcer of other sites unstageable and acquired absence of left knee and chronic kidney disease stage 4. R12's MDS (Minimum data Set) section C cognitive section scored BIMS (Brief Interview for Mental Status) at 15 indicating that R12 is cognitively intact. R13's admission Record showed documentation that R13 admission date was 11/11/2025 with listed diagnosis that includes but not limited to Respiratory failure unspecified, unspecified whether with hypoxia or hypercapnia, dependence on supplemental oxygen, muscle weakness (Generalized), need for assistance with personal care, and depression. R13's MDS (Minimum data Set) section C cognitive section scored BIMS (Brief Interview for Mental Status) at 15 indicating that R13 is cognitively intact. On 12/10/2025 between 11:10am to 11:27am, R12 observed in bed with V17 C.N.A (Certified Nurse's Aide) assisting R12 with AM (Morning) care Bed bath, soiled linen noted stored on the bare floor by the door. Surveyor observed V17 with gloved hands using wash cloth to wash R12 body and use the same soiled towel to wipe the mattress cover on the bed, then place the soiled towel on the side of the bed by R12's pillow. During this task R12 asked for his phone that was on the over the bed table, V17 use the same soiled gloves to pick up the phone from the over the bed side table and hand it over to R12. After R12 used of the phone, V17 took the phone and placed it back on the over bed side table and continue with the bed bath without any hand hygiene. During the same observation, R12's pillows that were observed on the bare floor, V17 picked them up with the same used soiled gloves and put them on the bed and transfer them on the chair. During this observation, V17 was observed using the same soiled glove hands used in cleaning R12 to touch the door knobs on the toilet door and the main door of the room to the hallway. V17 observed going out of R12's room into the hallway to the clean linen cart in the hallway without removing the soiled gloves or performing any hand hygiene to pick up clean linen from the cart and returning to the room to continue with care for R12. V17 handed a wash towel to R12 to wipe his private part, after use V17 took the wash towel and use it to wipe R12's back area. After the task V17 use same soiled gloves to pick up clean t-shirt for R12 to wear, use same soiled gloves to apply new incontinent diaper and body lotion on R12 skin. V17 removed R12 clothe that were on the bare floor with same soiled gloves and return them into R12's closet. V17 then proceed to R13's (roommate)'s bed picking up all the linen on the bed touching the bedside table and the two pillows on bed and placed on R12's recliner chair with the same soiled gloved hand. From 11:10am to 11:27am, V17 did not perform any hand hygiene throughout this observation and did not remove the soiled gloves till the end of the task. At approximately 11:27am, when the surveyor asked V17 about observations that was made during this task and was asked about facility protocol/policy on infection prevention and control regarding hand hygiene and use of gloves. V17 stated that I (V17) forgot to change my gloves; I was moving too fast, the soiled linens should have been in a plastic bag. I have so many soiled towels in the bed that I just use it to wipe the bed in cleaning the bed. V17 said I should not go in between resident with a soiled gloves or their things (belongings), I can see how that can transfer infection. I was just moving too fast. On 12/10/2025 between 11:36am to 11:42am, V3 (Infection Control Nurse) stated in part that the facility infection prevention and control must be followed by all staff to prevent any spread of infection. They (staff) must wash or use a sanitizer in-between resident care, change their gloves and wear proper PPE (Personal Protective Equipment) before going in and out of resident room. No going between residents during care or touching of resident's belongs without proper hand hygiene. Soiled linens should be in plastic bags contained when soiled and not on the bare floors. V3 stated that there should be no touching of the clean linen carts with</p>		