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	12/24/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident received care and services in accordance with professional standards of practice by failing to monitor potassium levels after initiation and continuation of potassium supplementation and by failing to recognize and act upon a critically abnormal laboratory value. The facility did not ensure timely laboratory monitoring for a resident receiving potassium and failed to notify the provider or initiate emergent medical intervention when a critically high potassium level of 8.4 mEq/L (normal range 3.5-5.1) was identified. These failures applied to one (R1) of three residents reviewed for nursing care and resulted in R1 not receiving medical intervention for critically high potassium level; R1 subsequently experienced cardiac arrest in the facility and expired four days after the laboratory result was obtained. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when the facility was notified of R1's lab report that showed a critical potassium level of 8.4 mEq/L (normal range 3.5-5.1) and the facility failed to provide R1 with care and services to address this abnormal value. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on [DATE] at 12:00PM. The survey team confirmed by observation, interviews, and record reviews that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include:R1 was a [AGE] year-old female admitted to the facility in [DATE]. R1 expired in the facility on [DATE]. R1 medical diagnoses included (but not limited to): chronic obstructive pulmonary disease, essential (primary) hypertension, hypertensive heart disease without heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, aneurysm of the descending thoracic aorta, without rupture, and aneurysm of the ascending aorta, without rupture.Review of R1's facility medical record show that R1 was being treated for low potassium levels (hypokalemia).R1 lab report dated [DATE] documents potassium level of 3.0 mEq/L (normal range 3.5 - 5.1); report flagged as containing abnormal results. This lab report was reviewed by V4 (Licensed Practical Nurse) on [DATE] 12:34. Nurse progress note written by V4 dated [DATE] 12:36 reads: CBC and CMP reviewed by NP and new order given for Potassium 40 Meq p.o. 1 x, noted and carried out. Review of Medication Administration Record (MAR) for R1 for [DATE] does not include any documentation that this order was administered to R1. There is no documentation or order showing that labs were ordered to be repeated after this intervention.R1 lab report dated [DATE] documents potassium level of 2.0 mEq/L (normal range 3.5 - 5.1); report flagged as critical. This lab report was reviewed by V4 on [DATE] 23:02. Nurse progress note written by V4 on [DATE] 23:53 reads: Spoke to V5 (Nurse Practitioner) to relay abnormal lab K+ 2.0, new orders given for Potassium 40 Meq p.o. x 3 days, repeat BMP in a.m., and give 5% dextrose 0.45% sodium chloride at 75ml/hr x 500ML. Noted and carried out. Supervisor is aware. R1 lab report dated [DATE] documents potassium level of 2.5 mEq/L (normal range 3.5 - 5.1); report flagged as containing abnormal results. This lab report was reviewed by V6 (Registered Nurse) on [DATE] 14:51. There is no documentation that V6 took any actions after reviewing this lab report in regard to the abnormal lab value. [DATE] at 2:02PM V6 (RN) was asked if she recalled caring for R1 and reviewing R1's lab values. While reviewing R1's EMR (electronic medical record) with surveyor present, V6 said yes, that she was the one who reviewed R1's labs on [DATE]. V6 confirmed that she would have documented in the progress notes if there were any new orders regarding the lab results. V6 was asked if she communicated this low potassium level to the nurse practitioner and V6 said that she recalled V5 (nurse practitioner) being in the building that morning and that they briefly talked about R1's labs but she didn't recall getting any new orders or instructions related to R1 and potassium levels. V6 also said that she took over that morning for V4 (LPN) because V4 was the overnight nurse but that she did not get report from V4 that morning because she thought that V4 had already left at the time that V6 got to work that morning. V6 was asked if she asked the nurse practitioner if there should be any new orders with the low potassium and V6 said she didn't since she assumed V5 was here and would have told her if she wanted any new orders. V6 confirmed that it is important to monitor potassium because of its relationship to the heart so it needs to be monitored closely.Review of physician orders for R1 show the following orders: - Potassium Chloride Crys ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride Microencapsulated Crystals ER) Give 2 tablets by mouth two times a day for hypokalemia (Order and Start Date [DATE] with no End Date noted)- Potassium Oral Tablet (Potassium) Give 40 mEq by mouth one time a day for low K+ for 2 Days x 3 days

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident was provided with continued assessment and monitoring while receiving potassium supplementation. This failure applied to one resident (R1) who was being treated for low potassium of 2.5 mEq/L and then continued to receive the potassium supplement with no plan for monitoring or follow up labs scheduled, in order to confirm the continued need for treatment. As a result, R1 was found to have a critically high potassium level of 8.4 mEq/L (normal range 3.5-5.1) when labs were re-checked 13 days later. Findings include:R1 was a [AGE] year-old female admitted to the facility in [DATE]. R1 expired in the facility on [DATE]. R1 medical diagnoses included (but not limited to): chronic obstructive pulmonary disease, essential (primary) hypertension, hypertensive heart disease without heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, aneurysm of the descending thoracic aorta, without rupture, and aneurysm of the ascending aorta, without rupture.Review of R1's facility medical record show that R1 was being treated for low potassium levels (hypokalemia).R1 lab report dated [DATE] documents potassium level of 3.0 mEq/L (normal range 3.5 - 5.1); report flagged as containing abnormal results. Nurse progress note written by V4 dated [DATE] 12:36 reads: CBC and CMP reviewed by NP and new order given for Potassium 40 Meq p.o. 1 x, noted and carried out. Review of Medication Administration Record (MAR) for R1 for [DATE] does not include any documentation that this order was administered to R1. There is no documentation or order showing that labs were ordered to be repeated after this intervention nor was there any indication of monitoring to be done related to this order. R1 lab report dated [DATE] documents potassium level of 2.0 mEq/L (normal range 3.5 - 5.1); report flagged as critical. Nurse progress note written by V4 on [DATE] 23:53 reads: Spoke to V5 (Nurse Practitioner) to relay abnormal lab K+ 2.0, new orders given for Potassium 40 Meq p.o. x 3 days, repeat BMP in a.m., and give 5% dextrose 0.45% sodium chloride at 75ml/hr x 500ML. Noted and carried out. Supervisor is aware. R1 lab report dated [DATE] documents potassium level of 2.5 mEq/L (normal range 3.5 - 5.1); report flagged as containing abnormal results. There is no documentation that V6 took any actions after reviewing this lab report in regard to the abnormal lab value. There is no documentation or order showing that labs were ordered to be repeated at this time. [DATE] at 2:02PM V6 (RN) was asked if she recalled caring for R1 and reviewing R1's lab values. While reviewing R1's EMR (electronic medical record) with surveyor present, V6 said yes, that she was the one who reviewed R1's labs on [DATE]. V6 confirmed that she would have documented in the progress notes if there were any new orders regarding the lab results.V6 said that she recalled V5 (nurse practitioner) being in the building that morning and that they briefly talked about R1's labs but she didn't recall getting any new orders or instructions related to R1 and potassium levels .V6 was asked if she asked the nurse practitioner if there should be any new orders with the low potassium and V6 said she didn't since she assumed V5 was here and would have told her if she wanted any new orders. V6 confirmed that it is important to monitor potassium because of its relationship to the heart so it needs to be monitored closely.Review of physician orders for R1 show the following orders: - (Order and Start Date [DATE] with no End Date noted) Potassium Chloride Crys ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride Microencapsulated Crystals ER) Give 2 tablets by mouth two times a day for hypokalemia - (Order Date [DATE], Start Date [DATE], End Date [DATE]) Potassium Oral Tablet (Potassium) Give 40 mEq by mouth one time a day for low K+ for 2 Days x 3 days - (Order Date [DATE], Start Date [DATE], with no End Date noted) Potassium Oral Tablet (Potassium) Give 40 mEq by mouth one time a day for low K+ x 3 days Medication Administration Record (MAR) for R1 [DATE] documents that R1 received Potassium Chloride Crys ER Oral Tablet Extended Release 20 MEQ (Potassium Chloride Microencapsulated Crystals ER) Give 2 tablet by mouth two times a day for hypokalemia -Order Date-[DATE] 1435 -D/C Date-[DATE] 1002; MAR shows that R1 was administered this medication on [DATE] and then twice daily (at 0800 and 1600) from [DATE] thru [DATE] and then in the morning on [DATE]. In total, R1 received 34 doses of this medication. [DATE] at 5:10PM V7 (Regional Consultant) confirmed that the nurse entered the order incorrectly, the resident was only supposed to get the potassium for 3 days but instead they kept giving it. Despite continued potassium supplementation, there was no documentation that the facility ensured ongoing and timely laboratory monitoring of potassium levels in accordance with professional standards of practice or ongoing assessment for continued need based on assessment, monitoring, or consultation with the ordering provider in relation to potassium supplementation being administered from

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that laboratory results were communicated to the ordering provider in accordance with facility policy and procedures for notification. This failure applied to one (R1) of three residents reviewed for notification of laboratory results and resulted in no provider being notified that R1 had a critical potassium level of 8.4 mEq/L (normal range 3.5-5.1), putting R1 at risk of cardiac arrythmia (irregular or abnormal heart rhythm). R1 subsequently experienced cardiac arrest in the facility and expired four days after the laboratory result was obtained. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when the facility was notified of R1's lab report that showed a critical potassium level of 8.4 mEq/L (normal range 3.5-5.1) and the facility failed to notify the provider of this critical value in order for it to be addressed. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on [DATE] at 12:00PM. The survey team confirmed by observation, interviews, and record reviews that the Immediate Jeopardy was removed on [DATE], when the facility initiated an audit process to verify code status and the deficient practice was corrected on [DATE]. This is being cited as past noncompliance.Findings include:R1 was a [AGE] year-old female admitted to the facility in [DATE]. R1 expired in the facility on [DATE]. R1 medical diagnoses included (but not limited to): chronic obstructive pulmonary disease, essential (primary) hypertension, hypertensive heart disease without heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, aneurysm of the descending thoracic aorta, without rupture, and aneurysm of the ascending aorta, without rupture.Record review for R1 revealed a laboratory result dated [DATE] which indicated a critically elevated potassium level of 8.4 mEq/L (normal range 3.5-5.1); report flagged as critical. Under the potassium lab value, it also says, SPECIMEN WAS CHECKED AND RESULT VERIFIED BY REPEAT TESTING. This lab report was reviewed by V4 on [DATE] 20:56. Nurse progress note written by V4 [DATE] 20:59:49 reads: Lab relayed to NP (V5) via phone, awaiting return response. There is no other documentation that V4 took any actions after reviewing this lab report in regard to the abnormal lab value nor was there confirmation that the provider was made aware of the critical lab value. Further, there was no evidence of nursing assessment or clinical intervention, and no initiation of emergent medical care in response to this critical potassium value.Employee disciplinary report for V4 documents - discharge: Date of Incident: 10/15: Description of what happened: Employee failed to contact MD regarding a critical lab. Employee should contact MD immediately for critical lab and receive respond [sic] before marking labs reviewed by Physician. Failure to adhere resulting in termination. V1 (Administrator) confirmed that V4 was terminated on [DATE].Job Description signed by V4 (LPN) on [DATE] include as part of Main Duties .P. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. Contact families regarding significant decline in resident's status or transfer to hospital documenting contact in the EMR.R. At all times abide by policies of the facility and ascertain that employees under his/her supervision do the same.W. Detect and correct situations that have a high probability of causing accidents or injuries to residents and/or staff.AF. Perform other related duties as directed by the DON, ADON, or Administrator.V4's Orientation Checklist signed on [DATE] documents that employee was instructed on reporting change of resident conditionXXX[DATE] at 1:52PM V9 (Licensed Practical Nurse/LPN) said that lab results come right to the dashboard (in the EMAR) and the nurse should print them out and notify the nurse practitioner (NP) right away. If it's in the evening after 6pm, the nurses can call telehealth and they will give orders or send the resident to the hospital. V9 said, if I call the provider and they don't respond and it's been an hour, depending on the resident assessment, I will call 911 and notify the director of nursing. I can also call the medical director. In the meantime, I would be monitoring the resident by checking vitals frequently and updating the manager. V9 added that when there is a critical lab value the lab will also call the facility in addition to uploading the reportXXX[DATE] at 12:42PM V10 (Registered Nurse) said that if there is a critical lab result, the lab will call and speak to the nurse and she would assess her patient and call the doctor right away. If it's after 5pm, she would call telehealth if she can't get a hold of the provider after 30 minutes. V10 added that for an elevated potassium, she would also hold any potassium supplements the resident is currently receiving and follow this up with the provider. V10 said that elevated potassium can cause arrythmias if it's over 5.0 and she would send the resident to the hospital due to the risk of fatal arrythmia. V10 added that the facility has recently provided in-service on reporting of critical lab values. [DATE] at 1:46pm V3 (Assistant Director of Nursing /ADON) said, after the resident coded