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	01/11/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were able to receive visitors of their choosing at the time of their choosing by limiting visitors after 8pm. This failure applied to two (R1, R5) of three residents reviewed for resident rights and has the potential to affect other residents in the building.Findings include:Facility provided current census of 158 residents.R1 is a [AGE] year-old resident admitted in March of 2025 with diagnoses including but not limited to: anoxic brain damage, acute and chronic respiratory failure, unspecified severe protein-calorie malnutrition, pressure ulcer of sacral region, stage 4, tracheostomy status, anemia, and gastrostomy status. R1 is nonverbal and unable to self-advocate and fully dependent on staff for care.1/9/26 at 12:09PM, V11 (R1 Family Member) said, I went yesterday and the tube feeding was off again -- I got there at like 6pm, that's the time I usually go between 5:45-6pm .last night they told me it was 8pm and it was time for me to leave because visiting hours were over and I told them I wasn't leaving until they turned it on. Surveyor asked V11 why she was asked to leave and V11 said, because that's the time visiting hours are over. That's how it's always been.R5 is a [AGE] year-old resident admitted in November of 2025 with diagnoses including but not limited to: anoxic brain damage, chronic respiratory failure, tracheostomy status, compression of brain, dependence on supplemental oxygen, and gastrostomy status.R5 is nonverbal and unable to self-advocate and fully dependent on staff for care.1/9/26 at 2:12PM, V13 (R5 Family Member) said, yesterday, at 8pm on the dot they came and kicked me out. I told them I wasn't leaving until they changed him because I was waiting for the staff to come clean him. Otherwise, I don't have any issues with them here. Surveyor asked V13 why she was asked to leave and V13 said, because that's the time visiting hours are over and that the nurse came was the one who came to the room and told her visiting hours were over. V13 said that she has met the wife of the roommate and she does not have a problem with her being there and that the wife even gave her, her phone number if she needed to call her for anything regarding her husband. At around 3:20PM, V13 saw surveyor walking on the unit and pointed to V9 (Licensed Practical Nurse) and said, that's the nurse who was working last night that asked me to leave.Due to R1 and R5's inability to communicate or self-advocate, staff enforcement of visitation limits directly determined whether the resident was able to receive visitors.1/9/26 at 3:30PM, V9 said, visiting is from 10am - 8pm. They announce it on the intercom. I have worked here two months, and it's been that way. On this unit, sometimes they can't hear in the rooms because of the ventilators so I tell them.1/9/26 at 3:25PM, V8 (Certified Nursing Assistant) said that visiting hours are from 8am - 8pm and that after 8pm visitors must go home.1/9/26 at 3:45PM V5 (Licensed Practical Nurse) said, visiting hours cut off at 8pm. No one is allowed after 8pm; that's not new, it's always been that way. There are exceptions for hospice or critically ill patients.1/9/26 at 3:48PM, V10 (Licensed Practical Nurse) said, visiting policy is 8am - 8pm. I don't know what happens if they come after 8pm because I work day shift.1/9/26 at (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3:51PM, V2 (Director of Nursing) said, for the sake of the residents and to have some kind of normalcy we having visiting hours. If someone wants to stay overnight it must be approved by V1 (Administrator) or myself; this is usually for hospice, new admissions, or for the comfort of the family. Reception leaves at 8pm and any visitors would buzz the doorbell, and it goes to the first-floor nurse's station. Visitors in the building don't have to leave, we don't go in (rooms) and tell them to leave. It's a safety concern in the middle of the night and at nighttime.1/11/26 at 3:13PM, V2 was for any protocols or policy that residents/families are provided with and V2 said there is nothing in writing because visitors aren't supposed to be turned away. V2 added that she would check with V1 (Administrator) to provide anything in writing.No documentation was found to support that the restrictions imposed on R1's or R5's visitors were based on individualized clinical need, resident preference, safety concerns, or the rights of others.Facility provided their Visitation guidelines (last review date 9/2/2025), which read:GENERAL: The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Therefore, if a visitor, resident, or their representative is aware of the risks associated with the visitation, and the visit occurs in a manner that does not place other residents at risk, the resident must be allowed to receive visitors as he/she chooses. RESPONSIBLE PARTY: All Staff DefinitionsVisitor: Any person chosen by the resident, including family, friends, partners, clergy, legal representatives, or advocates.Essential Caregiver: An individual designated by the resident to provide support or assistance with daily care needs (if applicable per state guidance).Visitation RightsResidents have the right to:Receive visitors of their choosing 24 hours a day, including immediate access by:PhysiciansSurveyorsOmbudsman representativesClergy or spiritual advisorsLegal representativesRefuse or limit visitation at any time.Privacy during visits.Visitation GuidelinesHoursOpen visitation is permitted at all times.Quiet hours are observed between 8pm to 8am to support resident rest.Check-In ProcessAll visitors must sign in at the front desk or designated entry point.Visitors may be asked to present identification per facility security procedures.Health and SafetyVisitors with symptoms of illness (e.g., fever, cough, vomiting, diarrhea) are discouraged from visiting.Hand hygiene is required upon entry and exit.During outbreaks or public health emergencies, additional precautions (e.g., masking, screening) may be implemented in accordance with public health guidance.Resident Care and ActivitiesVisits should not interfere with medical treatments, therapies, meals, or scheduled activities unless approved by the resident.Staff may request temporary adjustment of visitation to accommodate care delivery.Children VisitorsChildren are welcome but must be always supervised by an adult.Parents/guardians are responsible for ensuring children follow infection control practices.Reasonable RestrictionsThe facility may impose reasonable, temporary restrictions when necessary to:Protect resident safety or rightsAddress infection control concernsManage disruptive, threatening, or unsafe behaviorRespond to a resident's clinical condition or roommate rightsAny restriction will be:The least restrictive possibleClearly explained to the residents and visitorDocumented as appropriateCompassionate Care VisitsVisitation will be prioritized and supported during end-of-life situations, significant changes in condition, emotional distress, or other compassionate care circumstances, regardless of general restrictions.Abuse Prevention and ConductVisitors must:Respect resident dignity, privacy, and rightsFollow facility rules and staff instructionsRefrain from abusive, threatening, or inappropriate behaviorThe facility reserves the right to restrict or terminate visitation for violations of this policy or safety concerns.ComplianceThis policy complies with:42 CFR S483.10 (Resident Rights)Applicable state and local regulationsCMS and CDC guidance (as applicable)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who were unable to maintain adequate nutrition independently received enteral nutrition as ordered and failed to maintain accurate records of daily enteral intake for residents. This failure affected three of three (R1, R4, R5) residents reviewed for enteral feeding.Findings include:R1 is a [AGE] year-old resident admitted in March of 2025 with diagnoses including but not limited to: anoxic brain damage, acute and chronic respiratory failure, unspecified severe protein-calorie malnutrition, pressure ulcer of sacral region, stage 4, tracheostomy status, anemia, and gastrostomy status.R1 is nonverbal and unable to self-advocate and fully dependent on staff for care.01/09/26 at 4:18PM, V4 (Social Services Director) said, I know we had a care plan meeting with R1's family. We can give the family a narrative if they want a resolution to the concern. The concern forms are internal but if they request a concern form, they will get one.V4 (Social Services Director) provided the following documentation regarding the allegation that R1 had missed tube feeding: Incident Report NarrativeIncident Description:It was identified that the resident's feeding tube had been turned off for several hours, resulting in missed scheduled tube feeding. The issue was brought to staff's attention by the resident's spouse.Immediate Action Taken:Upon notification by the spouse, nursing staff responded immediately and turned the feeding tube back on to resume the ordered feeding. Nursing leaders were notified of the incident at that time. Physician was notified. Dietician was notified and new orders were put in place.Investigation / Findings:Review determined that the feeding interruption occurred due to staff oversight. The incident was addressed promptly once reported. There was no delay in response after the concern was communicated.Corrective Actions Implemented:An in-service training was conducted with the nursing staff involved, focusing on:Proper monitoring and verification of feeding tube functionEnsuring tube feedings remain on per physician ordersAccountability during shift-to-shift checksA customer service in-service was also completed to reinforce:Timely response to family concernsProfessional communication and follow-upFollow-Up / Prevention Plan:Nursing leadership will continue to monitor compliance with feeding tube protocols.Ongoing education and reinforcement will be provided as needed to prevent recurrence.Nursing note dated 11/30/2025 19:03 written by V12 (Registered Nurse) read: Note Text: At approximately 6:15PM writer was notified by NOD (Nurse on Duty) that the resident's spouse wants to talk to on shift supervisor. Writer immediately went to patient room. Patient's spouse verbalized concerns about the feeding machine that was off during her time of arrival at 6PM. NOD was already made aware and feeding machine was turned on and administered as ordered. Patient remains on stable condition, all vital signs monitored and within normal limits for the resident. Physician on call from telehealth, made aware of the concerns. No new order at this time. As per the doctor, no changes need to be made to patient feeding order at this time. Patient was immediately reassigned to a different nurse, as per his wife request. Staff will continue to monitor patient.01/09/26 at 4:39PM, V12 said, I cover the 3-11pm shift as the nursing supervisor. I was called to R1's room because the machine was stopped when the wife was there. The nurse made rounds, but I don't know what happened that the feeding had been stopped. When I got to the room the feeding had already been started, I think (I can't recall that well). We let the doctor know and I think the nurse contacted the dietician. I don't really remember much or who the nurse was, I had just started at that time and didn't really know people well.Progress note dated 11/30/2025 20:24 written by Telehealth Physician reads: Resident is PEG dependent and receives feeds from 2pm-11am daily. Wife arrived at facility @ 6pm to visit and noted that the pump was connected (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but feeds were not running. Wife very upset that feeds were not running btw 2p-6p. Feeds were immediately started once the notification was made .No new orders at this time. Please continue current feeding orders with TF running btw 2pm-11am as previously ordered.Nursing note dated 12/1/2025 08:13 written by V3 (ADON) reads: Note Text: The writer contacted the dietitian regarding the feedings the resident missed in previous days. The dietitian ordered three bolus feedings of TwoCal, 105 cc each, in addition to the continuous feeding. The order was entered into PCC, and the MD was notified.1/09/26 at 12:09PM, V11 (R1 Family Member) said, I went yesterday, and the tube feeding was off again -- I got there at like 6pm, that's the time I usually go between 5:45-6pm. It was beeping when I got into the room because it beeps when it's off -- it said INACTIVE. If it's paused for over 5 minutes, it will kick in automatically. When I asked the nurse yesterday, she didn't have an answer for me as to why it wasn't on. She said she was agency. It's happened twice this week. We had two meetings, the first time with the (V3) ADON, (V1) Administrator, and V4 (Social Services Director). This was around Thanksgiving. I told them he hadn't been fed for 8 hours, and they said it wasn't going to happen again. Then again during Christmas, I met with V2, V3 and the social worker. I explained again that he didn't eat for 6 hours. Last night they told me it was 8pm and it was time for me to leave because visiting hours were over, and I told them I wasn't leaving until they turned it on.1/9/25 at 3:25PM, V8 (Certified Nursing Assistant/CNA), said that when he goes in to change the resident (provide care) the feeding is paused, and the nurse gets notified to turn it back on.1/10/25 at 8:55AM, V7 (Licensed Practical Nurse/LPN), said when labeling the tube feeding, it should include the dosage, date, time started, and initials of the nurse. If it's an order for continuous feed it should be running continuously.R1 Physician order dated 12/23/2025:Formula: STD ENTERAL FEED 2 CalHN Rate: 50 mL/hr continuousTotal daily volume: 1200 mL/dayFlushes: every 4 hours 225 cc Free water flushOrders for R1 also include strict I&O monitoring (intake and output).On 1/10/26 at 8:47AM, the surveyor observed that R1's feeding pump was running at a continuous rate of 50mL with start time as 6AM. The 900mL feeding container had approximately 800mL remaining.Based on the ordered rate of 50mL/hr and the reported start time of 6AM, the container should have contained approximately 750mL at the time of observation; however, the observed volume did not correspond with the amount that should have infused. Additionally, the total fed volume on the feeding pump read 1115mL, which also did not correspond to the amount that should have infused according to the 6AM start time documented on the feeding container label.1/10/25 at 9AM, V2 (Director of Nursing) was asked how staff keep track of feedings administered via feeding tube and how resident intake is monitored (such as how much was received per bottle, when bottle was changed, etc.). V2 responded that there is no flow sheet to keep track of bottle changes. It just gets documented in the MAR (medication administration record). Regarding the missed feeding that the family member brought to the facility's attention previously, V2 said that she was not in the facility at the time but that it was addressed by the assistant director of nursing (V3) and that the nurse on duty at that time no longer works at the facility; she quit.R4 is a [AGE] year-old resident admitted in March of 2025 with diagnoses including but not limited to: respiratory failure, hemiplegia and hemiparesis following other cerebrovascular disease affecting unspecified side, unspecified severe protein-calorie malnutrition, anoxic brain damage, tracheostomy status, and gastrostomy status.R4 is nonverbal and unable to self-advocate and fully dependent on staff for care.R4 Physician order dated 12/23/2025:Formula: STD ENTERAL FEED: GT Jevity 1.5Rate: 80 mL/hr continuous x 20 hrs on at 2 pm Off 10 am or until total volume 1600 ml is infusedFlushes: every 6 hours Water flush 300 ml every 6 hrsOn 1/10/26 at 8:52AM, the surveyor observed that R4's feeding pump was running at a continuous rate of 80mL with no start time labeled. The 1000mL feeding container had (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately 900mL remaining.Based on the ordered rate of 80mL/hr and the ordered start time of 2PM, the container should have contained approximately 100mL at the time of observation; however, the observed volume did not correspond with the amount that should have infused. Additionally, the total fed volume on the feeding pump read 209mL, which also did not correspond to the actual volume observed. The lack of start time on the label made it unclear determination of when the feeding was started and if it had been running continuously as ordered.R5 is a [AGE] year-old resident admitted in November of 2025 with diagnoses including but not limited to: anoxic brain damage, chronic respiratory failure, tracheostomy status, compression of brain, dependence on supplemental oxygen, and gastrostomy status.R5 is nonverbal and unable to self-advocate and fully dependent on staff for care.R5 Physician order dated 12/3/2025:Formula: STD ENTERAL FEED VITAL 1.5 Rate: 70 mL/hr continuous x 21 hrs On 2 pm Off 11 amTotal daily volume: 1470 mL/dayFlushes: every 6 hours Water flush 250 ml q 6 hrsOn 1/10/26 at 8:49AM, the surveyor observed that R5's feeding pump was running at a continuous rate of 70mL with start time as 3AM. The 900mL feeding container had approximately 600mL remaining.Based on the ordered rate of 70mL/hr and the reported start time of 3AM, the container should have contained approximately 480mL at the time of observation; however, the observed volume did not correspond with the amount that should have infused. Additionally, the total fed volume on the feeding pump read 2836mL, which also did not correspond to the amount that should have infused according to the 3AM start time documented on the feeding container label; this amount is more than the daily volume ordered of 1470mL/day.1/11/25 at 3:13PM, V2 was asked about the discrepancy with the total fed volume not corresponding with what the feeding bottles contained and V2 confirmed that it's possible that when the new bottle was hung, staff did not reset the machine. V2 affirmed that the nurse should be resetting it when hanging a new bottled. V2 also provided MAR for R1 to show that tube feedings were administered but there is no time showing when the feedings were started or documentation of total volume received.Review of medical records for R1, R4, and R5 did not include documentation of when feedings were interrupted, stopped, or restarted and no accurate record of the total volume of tube feeding delivered daily.Review of the facility guideline titled Tube Feeding (review date 9/2017) includes: GENERAL: Nasogastric, gastrostomy and jejunostomy tubes are used when an alternate method of nutrition is needed.FEEDING PUMP:1. Use feeding set for pump and assemble per manufacturer instructions.2. Turn on pump, set prescribed rate and start feeding.3. Flush tube with water as ordered.4. Check residuals as ordered and alert Health Care Provider if there is more than 100 cc or other order.5. Pump should be cleared at the end of each shift.6. Document tube feeding delivered7. Alert Health Care Provider of any issues or concerns.