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	02/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to implement care plan interventions for a resident identified at risk for falls. This deficient practice statement affected one resident (R2) out of five reviewed. The findings include:R2 is a [AGE] year-old male originally admitted on [DATE] with medical diagnoses that include and are not limited to: acute respiratory failure, tracheostomy, schizoaffective disorder, and epilepsy. According to the Minimum Data Set (MDS) dated [DATE], R2 has a Brief Interview for Mental Status (BIMS) score of 10/15. R2 fall assessment dated : 5-17-2025 reads score of 15 (high risk for falls). According to R2's care plan, dated 7-3-2025, it reads: interventions: keep bed in lowest position. According to R2's nurses' notes dated 12-25-2025, it reads: R2's bed was left in an elevated position, the nurse observed R2's bed in a high position, and R2 was lying on the left side and sent emergently to a local hospital for evaluation. On 2-8-2026 at 10:20 AM, V2 (Director of Nursing) said on 12-25-2025 at 5:50 AM, R2 was observed on the floor after R2's bed was left in high position. I do not know who left the bed in a high position; the care plan for (R2) indicated that (R2) needed to be in a low position since (R2) is at high risk for falls. My expectation is for the nursing staff to implement the care plan interventions.On 2-8-2026 at 11:00 AM, V3 (Restorative Nurse) said, the staff is responsible for implementing the care plan interventions. I do not know why they left the bed in a high position. On 2/9/2026 at 4:20 PM, V1 (Administrator) said, My expectation is for the nursing staff to follow the care plan, which needs to be implemented to ensure the safety of (R2).On 2-8-2026 at 3:00 PM, V2 (Director of Nursing) presented policy titled: Comprehensive Care Plan, dated: 3-2025, reads: The facility must develop a comprehensive person-centered care plan for each resident. The comprehensive care plan should drive the care and services provided for the resident.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services in accordance with professional standards of nursing practice by failing to ensure effective communication of clinical information during the resident's transfer to the acute care hospital. This failure applied to two (R3, R5) of three residents reviewed for hospital transfer procedures.Findings include:1. R3 is a [AGE] year-old male with medical diagnoses that include: acute and chronic respiratory failure with hypoxia, dependence on respirator [ventilator] status, anoxic brain damage, epilepsy, and history of cardiac arrest.R3 was transferred to local hospital for change in condition on 12/17/25 and on 1/2/26.Nurse Progress note, Effective Date: 12/17/2025 03:08:00 written by V12 (Registered Nurse/RN) reads: Note Text: Client was sent to (local hospital) emergency room for GI Bleed per Dr order. Director of Nursing and family notified.Nurse Progress note, Effective Date: 12/17/2025 03:17:00 written by V12 (RN) reads: Note Text: Spouse was called but the phone was out of order will endorse to oncoming nurse.R3's Hospital Transfer Form completed by V2 (Director of Nursing) for transfer date of 12/17/25 is blank under section to document to whom report was called into.On 2/9/26 at 4:15PM, V2 (Director of Nursing) was asked if she called the hospital to provide nurse to nurse report when transferring R3 on 12/17/25. V2 said, I was helping the nurse. I didn't call the hospital, but I was helping fill out the forms.Upon request, the facility was asked to provide documentation or other evidence to demonstrate that a nurse-to-nurse report or verbal handoff communication occurred at the time of transfer. The facility was unable to provide documentation or evidence to support that effective transfer communication was completed.Nurse Progress note, Effective Date: 1/2/2026 19:18:00 written by V11 (RN) reads: Note Text: Resident was observed by staff with a heart rate between 130-150, as well as having seizure like movements/activity. NOD notified manager on duty as well as called the MD. Writer was able to obtain a telehealth call and got a new order to send the resident out 911. Resident was transported by 4 EMTS to ambulance. Family was notified of transfer.2/9/26 at 1:17PM, V11 (RN) confirmed that she was working an eight-hour shift at the facility on 1/2/26 through agency staffing. V11 stated she believed she had called report to the receiving hospital; however, she was unable to recall the name of the individual to whom report was given and there was no documentation in the medical record to reflect that a nurse-to-nurse report or verbal handoff communication occurred. V11 said she didn't remember getting any calls from the hospital about R3. V11 said, I did not know that (R3) was on hospice. It would be a major thing to communicate to the hospital because they need to know if he's a DNR, etc. I printed out three copies of the face sheets and the physician orders were given to the paramedics, and I remember giving report to the paramedics. I notified them of how long he was breathing like that, etc. I remember calling and notifying his family of his transfer.Review of R3's medical record shows that there was a hospice consent signed on 12/27/25 to initiate hospice care.1/2/26 SBAR form completed by V11 (RN) does not document that the resident is on hospice and it does not document any communication to the hospital.Upon request, the facility was unable to provide documentation or other evidence to demonstrate that a verbal handoff or nurse-to-nurse report was completed at the time of transfer for R3.2. R5 is a [AGE] year-old male with medical diagnoses that include: end stage renal disease, dependence on renal dialysis, acute pulmonary edema, heart failure, hypoxemia, anemia in chronic kidney disease, type 2 diabetes, and peripheral vascular disease.R5 was transferred to local hospital for change in condition on 1/2/26 and 1/20/26.Hospital transfer sheet provided for 1/2/26 completed by V13 (RN), nurse who initiated transfer, does not document who she called report in to the hospital.Review of medical record for R5 does not show any written nurse progress notes or other (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation from nursing regarding handoff or hospital transfer.2/8/26 at 4:52PM V2 (DON) was asked if she had any transfer documentation for R5 to show communication between the facility and the hospital and she said no.Nurse Progress note, Effective Date: 1/20/2026 04:14:00 written by V14 (Licensed Practical Nurse/LPN) reads: Note Text: Res. called 911, stated I don't feel good. This written was unable to assess him for discomfort prior to leaving due to the fact he hadn't voiced any c/o. Res. escorted via stretcher to [hospital] E.R. message left for next of kin.Hospital transfer sheet provided for 1/20/26 completed by V14 (LPN) does not document who she called report in to at the hospital.On 2/9/26 at 1:43PM, V14 (LPN) said, (R5) calls 911 all the time. Usually, he doesn't tell anyone and once 911 gets there they tell us who they are there for. The paramedics know him already, so they usually go back there and talk to him. I usually write a note that residents called 911 himself and call his family. I don't call the hospital to give report because it depends on what he tells them; they usually take him to the nearest hospital. I do complete the SBAR transfer form, and I just endorse it to the next shift. I don't know what happens after that because I work 11-7, usually he calls around 2-3 in the morning without telling anyone. I gave the EMT's the face sheet because that's what we're supposed to do. I didn't give them the POS (physician orders) because there was no order to send him out, he called himself. Surveyor asked V14 how the hospital knows what R5's current medications and treatment are since that information is not on the face sheet. V14 responded that the hospital already knows since he's been there so many times and they already know him. V14 said, If they (hospital staff) have any questions when he gets there, they will call but I don't remember them calling to ask about anything for him that time. If it's a facility-initiated transfer, then I get the order and send a list of meds and call and give report to the ER. I also call the family. We notify the family of where the resident is going so that they can call to follow up or if they want to go to the ER as well.2/7/26 at 4:16PM V2 (DON) said when a resident is transferred to the hospital, once the facility has obtained an order from physician, nurse should complete a transfer form in the medical record. Then they should complete an SBAR (also in medical record), they should also provide notification to the family. The nurse should call and follow up with the hospital. When sending a patient to the hospital, the nurse should call and give report to the hospital nurse, and they should send the resident with a Face sheet and POS (physician order sheet). If a resident is in hospice, it should be in the POS that they are on hospice, and I think that it's on the Face sheet as well. If the person is a DNR (Do Not Resuscitate) they should send a copy of it. The nurse should document what they did in the progress notes.Facility policy titled Discharges last reviewed 9/2017 includes:GENERAL:To establish a plan of how to discharge a resident from the facility to home, another facility, or the hospital.RESPONSBILE PARTY:RN, LPN, Social ServicesGUIDELINE: DISCHARGEHOSPITAL TRANSFER:1. Notify the physician regarding a change in resident/patient status and obtain an order fortransfer to the hospital. This may be a direct admit or an emergency room admission.2. If attending physician is not available, contact the medical director.3. Arrange transportation, either paramedics or ambulance depending on the status of theresident/patient.4. Inform the resident/patient and the resident's/patient's responsible party of the transfer.5. Prepare an ‘eINTERACT' transfer form.6. Document in the Progress Notes the condition of the Resident/Patient, who wasnotified of the transfer, where the resident/patient is going, mode of transportation,disposition of resident/patient belongings and medications, notification to allparties of the discharge.CMS requires care consistent with professional standards. Professional nursing standards require effective communication during transitions of care. The facility failed to demonstrate that effective handoff communication occurred.American Nurses Association (ANA) states nurses are responsible for: communicating relevant information (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during transitions, ensuring continuity of care, and accurate and timely exchange of information.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to follow its fall prevention policy as evidenced by:Failure to complete fall risk evaluations/assessments prior to and following resident falls.Failure to document a resident's fall.This deficient practice affected two residents (R2 and R4) out of five residents reviewed. The findings include:1. R2 is a [AGE] year-old male originally admitted on [DATE] with medical diagnoses that include and are not limited to: acute respiratory failure, tracheostomy, schizoaffective disorder, and epilepsy. According to the Minimum Data Set (MDS) dated [DATE], R2 has a Brief Interview for Mental Status (BIMS) score of 10/15. R2 fall assessment dated : 5-17-2025 reads score of 15 (high risk for falls). Per R2 progress note dated: 12-25-2025 at 5:50 AM reads: R2's was noted on the floor. On 2/8/2026 at 12:20 PM, V2 (Director of Nursing) said, any fall assessment score greater than 10 indicates a patient is at risk for falls. R2's fall assessments all resulted in scores greater than 10, indicating that R2 was at high risk for falls on the following dates:5-17-2025 score of 15 (high risk for falls),9-23-2025 score of 13 (high risk for falls),12-25-2025 score of 25 (high risk for falls),12-28-2025 score of 25 (high risk for falls) and 1-7-2026 score of 23 (high risk for falls).On 12/9/2025 at 8:15 AM, R2 rolled out of bed and was sent to a local hospital for evaluation. There are not any fall and pain assessments completed after the fall. 2. R4 is a [AGE] year-old male originally admitted on [DATE] with medical diagnoses that include and are not limited to: hemiplegia and hemiparesis, diabetes, vascular dementia with anxiety, and tracheostomy. According to the Minimum Data Set (MDS), R4 has a Brief Interview for Mental Status (BIMS) score of 13/15, cognitively intact. R4 is no longer at the facility. R4 fall assessment dated : 11-24-2025 reads score of 14 (high risk for falls). Per R4 progress note dated: 1-11-2026 at 8:19 AM reads: upon rounds (R4) was noted sitting on the buttocks on top of the floor mat next to the bed. R4 was sent to a local hospital for evaluation. On 2/8/2026 at 1:00 PM, V2 (Director of Nursing) said, any fall assessment score greater than 10 indicates a patient is at risk for falls. R4's fall assessments all resulted in scores greater than 10, indicating that R4 was at high risk for falls on the following dates:1. 11-24-2025 score of 14 (high risk for falls),2. 12-2-2025 score of 22 (high risk for falls)3. 12-15-2025 score of 24 (high risk for falls) and4. 12-26-2025 score of 22 (high risk for falls).V2 said, I do not see a completed fall report for the fall that occurred on 1/11/2026. Additionally, I do not see any documented post-fall assessments following the falls sustained by R4 on 12/3/2025 and 1/11/2026. My expectation is for the nursing staff to complete the required fall report/risk management documentation, as well as post-fall and pain assessments, following every fall. Failure to complete the appropriate documentation after a fall is unacceptable.On 2-8-2026 at 12:00 PM, V3 (Restorative nurse) said, the nurse documented on 1-11-2026: R4 was on the floor. I do not have any fall report or investigation. The nurse failed to complete the risk management for the interdisciplinary team to investigate, and the patient went to the hospital and never came back. I did not receive any fall report, and no fall assessment was documented. I expect the nurse to document accurately and completely. On 2/9/2026 at 4:20 PM, V1 (Administrator) said, My expectation is for the nursing staff to complete risk management and fall assessments and update care plan interventions after a resident's fall. The nursing management needs to ensure all documentation is complete.On 2-7-2026 at 3:00 PM, V2 (Director of Nursing) presented policy titled: Fall Prevention and Management, dated: 9-2025, reads: The facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. A fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk evaluation will be completed on admission, readmission, quarterly, and after each fall.Facility Guideline following a fall incident:Complete a fall incident report in the PCC risk management portal. A fall risk evaluation is completed by the Nurse. A score of 10 or greater indicates the resident is at high risk for falls; a score of less than 10 indicates at risk for falls.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure coordination and integration of hospice services into the resident's plan of care by not incorporating resident request for hospice enrollment into the resident's active physician orders, failing to ensure nursing staff were aware of the resident's hospice status, and failing to communicate hospice enrollment during a hospital transfer. This failure applied to one (R3) of three residents reviewed for hospice services.Findings include:R3 is a [AGE] year-old male with diagnoses including acute and chronic respiratory failure with hypoxia, ventilator dependence, anoxic brain damage, epilepsy, and history of cardiac arrest.Review of the medical record revealed a hospice consent signed on 12/27/25 initiating hospice services.Review of R3's most current POS (physician order sheet) does not include any physician orders for hospice and there is no documentation on R3's face sheet indicating hospice status.R3 was transferred to the hospital on [DATE] and there was no documentation to show that communication to the hospital was provided.SNF to Hospital Transfer Form for transfer on 01/02/26 at 19:08 documents that report was called in to ER but there is no indication on the form that R3 was on hospice.Nurse Progress note Effective Date: 1/2/2026 19:18:00 written by V11 (Registered Nurse/RN) reads:Note Text: Resident was observed by staff with a heart rate between 130-150, as well as having seizure like movements/activity. NOD notified manager on duty as well as called the MD. Writer was able to obtain a telehealth call and got a new order to send the resident out 911. Resident was transported by 4 EMTS to ambulance. Family was notified of transfer.On 2/9/26 at 1:17PM, V11 (RN) said she was working at the facility through an agency service on 1/2/26 and transferred R3 out to the hospital. V11 said, I don't remember but I believe that I did call the hospital, and I gave report to the EMT.I don't remember getting any calls from the hospital. I did not know that (R3) was on hospice. It would be a major thing to communicate to the hospital because they need to know if he's a DNR, etc. I printed out three copies of the face sheets and the physician orders were given to the paramedics.2/7/26 at 4:16 PM, V2 (Director of Nursing) stated that if a resident is on hospice, it should be reflected in the Physician Order Sheet and on the Face sheet.2/9/26 at 4:15PM, V2 (DON) said that once the hospice consent is signed social service should put the order in the POS (physician orders). I don't know where the breakdown was, but they would usually tell the nurse on the unit.The facility was unable to provide documentation demonstrating that hospice enrollment was incorporated into the resident's active orders or clearly communicated to nursing staff responsible for the resident's care.CMS regulations require the facility to coordinate hospice services with the hospice provider and ensure hospice care is integrated into the resident's plan of care.The facility's failure to ensure staff awareness and integration of hospice status resulted in hospice enrollment not being communicated during hospital transfer, placing the resident at risk for care inconsistent with hospice goals and the resident's end-of-life preferences.Facility Hospice policy (last reviewed 9/2024) reads:GENERAL: To provide guidance on how hospice services will be administered within the facility. A written agreement with the hospice that is signed by an authorized representative of the of the hospice and an authorized representative of the LTC facility before hospice care is furnished to a resident.PURPOSE: Ensure that the hospice services meet the professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.RESPONSIBLE PARTY: IDTThe written contract must include the following:PROTOCOL:1. The services the hospice will provide2. The hospice's responsibilities for determining the appropriate hospice plan of care3. The Services the LTC facility will continue to provide based on each resident's plan of care4. A (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.5. A provision that the LTC facility immediately notifies the hospice about the following:a. A significant change in resident's physical, mental, social, or emotional status.b. Clinical complications that suggest a need to alter the plan of carec. A need to transfer the resident from the facility for any conditiond. The resident's death6. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.7. An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.8. A delineation of the hospice responsibilities, including but not limited to, providing medial direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.9. A provision that the LTC facility personal are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care.HOSPICE COMMUNICATION:1. Hospice representative and facility staff will have conduct a Care Plan meeting with resident and resident' representative.2. During the Care Plan meeting, the hospice plan of care will be developed. During the care plan it will be determined what type of services will be needed or NOT needed for the specific resident i.e. SPO2 readings, Lab testing, weights etc 3. The facility will have a designated staff member who serves as the hospice care coordinator.4. Any hospice staff will communicate verbally and when necessary, in writing with the facility staff every visit the outcomes of the hospice visit.5. The facility staff will consult hospice before any changes in the resident's plan of care occur, change in condition, and any other information that may be of benefit.