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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Elmwood Park	7733 West Grand Avenue Elmwood Park, IL 60707

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to follow policy procedures and failed to submit a facility reported incident to IDPH (Illinois Department of Public Health) within regulatory requirements for one of three residents (R6) reviewed for abuse. Findings include:On 3/20/26, IDPH (Illinois Department of Public Health) received an abuse allegation perpetrated by facility staff.On 5/18/26 at 11:10am, surveyor inquired about the facility abuse protocol V1 (Administrator) stated If there's an abuse allegation, they (staff) report it to me (V1). If the perpetrator is a staff member they are suspended, a police report is made, I (V1) interview the resident or the person making the allegation and send the State a report within 2 hours. I have 5 working days to investigate and submit a final. Surveyor requested R6's (5/14/26) facility reported incident/investigation at this time.On 5/18/26 at 11:34am, V1 presented an email (not a facility reported incident form) sent from a Gmail account which includes subject: alleged verbal abuse preliminary report. The email states Please accept this email as a preliminary report of alleged verbal abuse. I (V1) was called at 5:54pm today and told that there was an allegation of alleged abuse. The alleged incident happened on May 14th at approximately 4:30pm. CNA/Certified Nursing Assistant (V4's Name) was answering a call light. The resident is [R6's first name]. Resident's husband reported that he witnessed (V4) yell at resident to not sit up. (V4) has been suspended pending the investigation. Police were called and a report has been filed. The resident's physician had been notified. Resident's husband has been notified. No injuries reported. The email was submitted to IDPH on 5/15/26 at 7:46pm - however required information (R6's last name, age, diagnosis, and mental status) and facility reported incident form were excluded.On 5/19/26 at 11:37am, surveyor inquired if R6's (5/14/26) abuse allegation was reported to IDPH within 2 hours V1 responded Yes. Surveyor inquired why a Facility Reported Incident Form was not submitted to IDPH on 5/15/26 - when staff were notified of alleged abuse V1 replied I (V1) don't have a laptop yet. That's why I put on there (referring to email) I hope you'll accept this initial. Surveyor inquired if the (5/14/26) initial Facility Reported Incident was submitted to IDPH yet V1 replied Yesterday (5/18/28) I started putting it on an official form but when I submit the final, I'll submit the real form with all the data transferred over. Surveyor inquired why R6's last name was excluded from the email submitted to IDPH on 5/15/26 V1 stated I used my Gmail and there was HIPAA (Health Insurance Portability Accountability Act), I don't know if it was encrypted and didn't want to break any HIPAA laws. R6's (initial) facility reported incident form was submitted to IDPH (via email) on 5/20/26 (5 days after staff was made aware of alleged abuse).The facility Abuse policy (reviewed 9/2017) states that 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 report shall include the following information, if known at the time of the report: Name, age, diagnosis of mental status of the resident allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated. Date, time, location and circumstances of the alleged incident.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based upon interview and record review, the facility failed to follow policy procedures and failed to conduct a thorough investigation for two of three residents (R4, R5) reviewed for abuse. Findings include:On 3/20/26, IDPH (Illinois Department of Public Health) received allegations that sometime in March and unknown male CNA (Certified Nursing Assistant) told R4 they could choke her.On 5/18/26 at 9:22am, surveyor inquired about R4's alleged abuse V3 (Family) stated I (V3) don't know who the staff was because they (facility) never followed up with me (V3). Surveyor inquired if R4 currently resides at facility V3 affirmed that she (R4) does not. The 3/23/26 (initial) facility reported incident form states (R4) alleged that a day or two after she admitted to the facility. She was calling a staff member for assistance, and she overheard (from outside her room) two staff members talking to each other saying that they will choke her out. She stated that a tall light skin staff member confirmed that was said. There is no known witness at this time. The 3/23/26 (final) facility reported incident form states we have received statements from several staff that are regularly assigned to work on the first floor and specifically assigned to work with (R4). No one has heard any of the statements that (R4) reports were made and no staff have had a conversation with (R4) stating that staff want to harm her. Based on staff statements, and the fact that staff respond to her room in pairs the allegation of verbal abuse is unsubstantiated. [The facility reported incident form includes interview of other residents: write summary of interview(s) with other residents who may have had contact with the alleged perpetrator however interviews of witnesses/documented statements - exclude R4's roommates and/or other facility residents]. On 5/18/26 at approximately 10:00am, V1 (Administrator) affirmed he's been employed at the facility for 1 month - therefore after the 3/23/26 alleged incident. On 5/19/26 at 1:40pm, surveyor inquired if resident interviews were obtained/documented during the 3/23/26 abuse investigation. V1 subsequently reviewed the statements with surveyor and affirmed that resident interviews were excluded. Surveyor inquired about required interviews for abuse investigations V1 stated I (V1) think the resident should be interviewed, the resident roommates, probably the resident across the hall that could hear something, staff that worked and the supervisor that worked so we have as much information as possible. __R5's diagnoses include quadraplegia. R5's (5/11/26) functional assessment affirms the resident is dependent on staff for all ADL (Activities of Daily Living) care. R5's (11/4/25) care plan includes Abuse/Neglect/Trauma. Resident states he has been a victim of gun violence, interventions: encourage resident to verbalize any instances of abuse. Provide a safe environment. R5's (5/11/26) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact). On 5/18/26 at 1:30pm, surveyor inquired about concerns at the facility R5 stated Maybe 3 weeks ago, I (R5) was getting handled by 2 CNAS who talk how they want. (V5/CNA's name) put her (V5) hands on me (R5). I (R5) don't really turn to the left because it hurts. She (V5) turned me to the left and I said ah, ah, I'm in pain. I told her she was going too fast. She told me to shut up, I called her the B word because I was hurting. I told the supervisor that (V5) put my head in the pillow, and I couldn't breathe. The 5/5/26 (initial) facility reported incident form states (R5) stated (V5) allegedly hit him in the face. No injury identified. The 5/5/26 (final) facility reported incident form includes interview of alleged victim, interview of alleged perpetrator (V5), interview of witness (V12/CNA), interview of other residents states Due to the diagnosis of nearby residents, they were unable to interview. Conclusion: after a thorough investigation including witness statements from staff that were present during the alleged incident, the allegation of abuse is unsubstantiated. There was a witness in the room the entire time, when the alleged abuse was to occur. The witness says that (V5) did not abuse (R5) physically, mentally, or verbally. Furthermore, there was no evidence to support that any inappropriate physical actions occurred based on the nurse's assessment that was completed right after the alleged incident. On 5/20/26 at 10:26am, surveyor inquired about R5's (5/5/26) abuse investigation V1 stated I (V1) spoke to him (R5), I spoke to the person he (R5) accused (V5), I spoke to the CNA (V12) that went in there, I spoke to an RT (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Respiratory Therapist) that didn't witness anything but she (RT) heard (R5) yelling and said it was (V5) saying that's disrespectful and said she (RT) saw the CNA leave. I think that was it. Surveyor inquired if any residents (besides R5) were interviewed during the investigation V1 responded I couldn't interview his roommates because they (roommates) were non-verbal. There was no one across the hall, there's' an office there and the 2 residents next door are non-verbal. Surveyor inquired if V1 interviewed residents that V5 was assigned to V1 replied I did not, it was my first investigation in an extremely long time and I followed a template, I haven't done one in 20 years. Surveyor inquired if the facility policy was followed V1 stated I haven't read the policy, I went according to the template (referring to the facility reported incident form) and some guidance of regional.The facility Abuse policy (reviewed 9/2017) includes investigation procedures: the appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interview able. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked will be interviewed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow policy procedures and failed to develop a baseline care plan within 48 hours of admission for three of four residents (R1, R4, R6) reviewed for abuse and falls. Findings include:R1 was admitted on [DATE]. R1's potential for abuse care plan was initiated on 4/27/26 - (18 days after admission). On 5/21/26 at 10:13am, surveyor inquired about baseline care plan requirements V14 (Care Plan Coordinator) replied Within 72 hours upon admission the nurses on the floor should be opening up a baseline care plan. It would be developed within 48 hours but would be in there within 72 hours. Surveyor inquired if R1's baseline care plan includes abuse V14 reviewed R1's EMR (Electronic Medical Records) and stated No, no abuse is in there. Surveyor inquired when R1's abuse care plan was initiated, V14 responded 4/27.R4 was admitted on [DATE].R4's (3/23/26) facility reported incident states (R4) alleged she overheard two staff members talking to each other saying that they will choke her out. R4's abuse/neglect care plan was initiated on 3/25/26 - after 3/23/26 abuse allegation (6 days after admission). On 5/21/26 at 10:25am, surveyor inquired when R4 was admitted V14 Care Plan Coordinator) stated 3/19 of 2026. Surveyor inquired if R4's baseline care plan includes abuse V14 reviewed R4's EMR and responded No. Surveyor inquired when R4's abuse care plan was initiated V14 replied 3/25.R6 was admitted on [DATE].R6's 5/5/26 (admission) fall risk evaluation determined a score of 11 (high risk).R6's (5/16/26) incident report states upon staff entering room to answer call light, resident was observed on the floor on the side of her bed. R6's fall care plan was initiated on 5/18/26 - after 5/16/26 fall (13 days after admission).R6's (5/14/26) initial facility reported incident states (R6's) husband stated the nurse aide (V4/Certified Nursing Assistant) allegedly yelled at resident. R6's abuse care plan was initiated on 5/17/26 - after 5/14/26 abuse allegation (12 days after admission). On 5/21/26 at 10:28am, surveyor inquired when R6's admission fall risk assessment was conducted V14 stated She (R6) has a 5/5 fall risk assessment. Surveyor inquired if R6 has a baseline fall care plan V14 responded She doesn't have one. Surveyor inquired when R6's fall care plan was initiated V14 replied 5/18. Surveyor inquired if R6 has a baseline abuse care plan V14 stated I (V14) only have 5/17 the comprehensive.The baseline care plan policy (revised 09/2025) states the baseline care plan will be developed within 48 hours of a resident's admission into the facility. The baseline care plan will include at minimum the following necessary information to properly care for a resident: fall risk.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to follow policy procedures, failed to follow physician orders, failed to follow the facility assessment tool, failed to schedule required nursing staff, and failed to ensure that sufficient nursing staff were available to meet the needs for four of four residents (R2, R3, R8, R9) reviewed for medication administration. These failures have the potential to affect 174 residents residing in the facility.Findings include:The 5/18/26 facility census includes 174 residents.The 8/1/25 Facility Assessment Tool includes Licensed Direct Care Nurses/Total # of staff needed or average range: LPN's (Licensed Practical Nurses) and RN's (Registered Nurses) staffed based on census x minimum staffing hours required. Other: All floors are staffed with 2 Nurses per shift. Staffing Plan: the facility checks daily staffing needs census, skilled and non-skilled residents. The facility is staffed to meet the acuity needs of facility residents. The facility also has a labor budget that it follows which meets the minimum staffing requirements according to regulations. [The facility has 4 floors - therefore a minimum of 8 Nurses is required].On 5/11/26, IDPH (Illinois Department of Public Health) received allegations that (R2's) medications were not administered (as directed) at the facility due to lack of nursing staff.On 5/18/26 at 1:04pm, V7 (Infection Prevention Nurse) was observed accessing the (1st floor) medication cart. Surveyor inquired about facility staffing concerns V7 stated I'm (V7) infection control but I'm working the cart, were (facility) short of Nurses. I (V7) think people called off and affirmed that she was currently assigned on the 1st floor. R2's (5/10/26) progress note states 9:14pm, patient called 911 and went out. Nurse reported that she went as nurse did not arrive to room in time to give her medication.R2's (3/27/26) BIMS (Brief Interview Mental Status) determined a score of 14 (cognition intact).On 5/26/26 at 3:14pm, surveyor inquired why R2 called 911 (on 5/10/26). R2 stated, I (R2) didn't get my pain meds or any other meds, nothing and affirmed this occurred on 3pm-11pm shift due to no Nurse assigned. The 5/10/26 (3pm-11pm) Nursing Assignment Sheets include 1 nurse assigned to 1st floor (team 2 entry was blank), 1 nurse assigned to 4th floor (team 2 entry was blank), 2 nurses assigned to 2nd floor and 2 nurses assigned to 3rd floor therefore only 6 Nurses were scheduled [8 Nurses are required - per facility assessment tool].R2 resides on 4th floor (team 2).R2's POS (Physician Order Sheets) include (8/9/23) Metoprolol Tartrate 25mg two times a day, Topiramate 25mg at bedtime, and (1/3/26) Famotidine 20mg two times a day.R2's MAR (Medication Administration Record) affirms on 5/10/26 - evening shift (blank) entries were noted for Famotidine (scheduled for 4pm administration), Metoprolol Tartrate (scheduled for 5pm administration), and Topiramate (scheduled for 9pm administration).On 5/26/26 at 11:21am, surveyor inquired about required facility Nurse staffing V2 (DON/ Director of Nursing) replied It should be at least 2 nurses on each floor and affirmed this was for each shift. Surveyor inquired why only one (1) nurse was assigned to 4th floor on 5/10/26 (evening shift) if two (2) nurses were required. V2 stated, It probably was initially scheduled with 2 people and for whatever reason maybe the 2nd person didn't come. Surveyor inquired how one (1) Nurse (assigned to 56 - 4th floor residents) can administer medications timely. V2 responded, The Nurses come from the different floors and do the med pass. Surveyor inquired how someone determines who administered medications to the 4th floor residents on 5/10/26 evening shift (if excluded from the schedule). V2 replied, Typically the MAR (Medication Administration Record). Surveyor inquired about facility staffing concerns. V2 stated, We (facility) consistently look for more and more staff. Certain days are a little more challenged than others. This particular one (referring to Sunday 5/10/26) is the short weekend. We switched to using a staffing company and it started off a little rocky. When we are short, the nurses do get together and do the med passes on the floor, but we haven't had staffing issues moving forward. Surveyor inquired what a blank entry on the MAR indicates. V2 responded, If it's not documented, it wasn't done.__R8 resides on 4th floor (team 2).R8's (4/16/26) BIMS determined a score of 14.R8's POS includes (7/16/25) Hydralazine HCL 50mg three (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	times a day and Metoprolol Tartrate 25mg two times a day. (4/29/26) Gabapentin 100mg three times a day. (5/3/26) Lantus 100units/ml, inject 22 units at bedtime. On 5/18/26 at 2:04pm, surveyor inquired if R8 has any medication administration concerns. R8 responded, No however R8's (5/10/26) MAR affirms (blank) entries were noted for Metoprolol Tartrate (scheduled for 5pm administration), gabapentin (scheduled for 5pm administration), Lantus (scheduled for 9pm administration), and Hydralazine (scheduled for 9pm administration). __R9 resides on 4th floor (team 2).R9's (4/24/26) BIMS determined a score of 15 (cognition intact).R9's (10/3/25) POS includes Advair Diskus Aerosol Powder 250-50 micrograms/dose. 1 inhalation every 12 hours. On 5/26/26 at approximately 3:14pm, surveyor inquired about concerns at the facility. R9 affirmed that on 5/10/26 (evening shift) there was no nurse assigned to the unit and stated, I (R9) have an inhaler I should get at 8:00pm, that's a problem.R9's (May 2026) MAR affirms (blank) entries were noted for Advair (scheduled for 9pm administration) on 5/4, 5/5, and 5/10.On 5/26/26 at 12:06pm, surveyor inquired about staffing concerns. V16 (LPN) stated, The weekends are short more often than during the weekdays. I (V16) don't know if it's because they have a new outside source doing the schedule and they find the people, or somebody calls off and they're in charge of finding a replacement. Surveyor inquired about required Nurse staffing. V16 responded, It's supposed to be 2 Nurses assigned to 1st, 2nd and 4th floor and 3 Nurses are assigned to 3rd floor in the mornings and evenings therefore a total of 9 Nurses. Surveyor inquired if V16 passed (4th floor) medications on 5/10/26 (evening shift) when she (V16) was assigned to the 2nd floor (per nursing assignment sheet). V16 responded, No, me personally? No. Surveyor inquired if V16 has time to assist with passing medications on other floors when assigned to roughly 25 (2nd floor) residents. V16 replied, Speaking for myself, no. On 5/10/26 (evening shift), V17 (Agency LPN) was the Nurse assigned to 4th floor per V2 (DON).On 5/26/26 at 1:59pm, surveyor inquired why R2 called 911 on 5/10/26 (evening shift). V17 stated, I (V17) didn't know that anybody called 911. I was all by myself and they (facility) didn't' have a Nurse on the other side (Team 2). I'm (V17) from the agency, not familiar with the patient and the supervisor wasn't responding to anything so I was all by myself. Nobody informed the Nurse, the resident (R2) didn't inform me (V17), and the CNA (Certified Nursing Assistant) didn't inform me. So, I wasn't aware. Surveyor inquired if other Nurses assisted with medication administration on 5/10/26 (evening shift). V17 responded, No, the supervisor came, she (supervisor) did nothing and she left. I couldn't get a login until 5:00pm and I started at 3:00pm. Surveyor inquired if all the 4th floor residents received (evening shift) medications on 5/10/26. V17 replied, I was able to pass meds to people on my side (Team 1) and the other side (Team 2) I only did some of the medications. They (residents) were all complaining, the people (residents) on the other side were angry, some were yelling, and I told the supervisor that you don't have somebody on the other side. On 5/27/26 at 11:02am, surveyor inquired about the required 3pm-11pm facility Nurse staffing. V20 (Nurse Supervisor) stated, 3-11 shift we (facility) run with 9 nurses: 2 on each floor (1st, 2nd, 4th), and 3 on 3rd floor and affirmed that this excludes the Nurse Supervisor. Surveyor inquired about the 5/10/26 (3pm-11pm) Nurse staffing. V20 responded, I (V20) didn't work that day, I work every other weekend and that was my (V2) day off. They (facility) normally have a MOD (Manager on Duty) from different departments that take turns, on the other weekends - sometimes it's a nurse. V20 reviewed the (5/10/26) evening shift Nursing Assignment Sheets (as requested) and stated We (facility) have 6 Nurses. Surveyor inquired if on 5/10/26 the (1st floor) had only one Nurse scheduled. V20 responded, That's what they (facility) have written on the paper. Surveyor inquired if on 5/10/26 the (4th floor) had only one Nurse scheduled. V20 replied, That's what they have written in. Surveyor inquired who assists with medication administration if only 1 Nurse is assigned to the unit. V20 stated, Since I've (V20) been the supervisor (2 weeks ago) when there's only 1 nurse, I help pass meds. Surveyor inquired who assists with passing medications if the MOD is not a Nurse. V20 responded, That I wouldn't be able to answer cause I'm (V20) not here.R3's R3's diagnoses include sepsis. R3's (4/10/26) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact).On 5/18/26 at 12:52pm, surveyor inquired (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	about medication administration concerns at the facility. R3 stated They (facility) didn't have my (R3) Vancomycin, they ran out of it. I (R3) finally got it today.R3's (5/15/26) POS (Physician Order Sheets) include Vancomycin 25mg (milligrams)/ml (milliliter) give 5 ml (milliliters) every 6 hours. R3's (May 2026) MAR (Medication Administration Record) affirms 9 (See Nurses Note) was documented on 5/17 at midnight, 6am, 12pm, and 6pm. 9 was also documented on 5/18 at midnight and 6am. R3's (5/17/26) progress notes state 1:35pm, Vancomycin: spoke with pharmacy, medication will be delivered with delivery today. 9:31pm, Vancomycin: awaiting pharmacy delivery. On 5/21/26 at 12:57pm, surveyor inquired what 9 indicates on the MAR. V2 (Director of Nursing) stated, Other, see nurses note. Surveyor inquired about R3's 5/17/26-5/18/26 Vancomycin administration V2 reviewed R3's (May 2026) MAR and responded On the 17th, he (R3) has a 9 for midnight, 6am, 12pm, and 6pm. On the 18th he has a 9 for 12 midnight and 6am. Surveyor inquired if R3's Vancomycin was unavailable V2 reviewed R3's progress notes and replied, This says at 9:31pm on 5/17 the nurse signed out that she was awaiting pharmacy to deliver. On 5/17 at 1:35pm, she (Nurse) did not have the medication available. Surveyor inquired how many doses of Vancomycin R3 didn't receive. V2 stated, I'm (V2) seeing 6 doses. The medication administration policy (revised 10/2025) states verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. If medication is not given as ordered, document the reason on the MAR. The staffing policy (reviewed 9/2025) states staffing is based on the IDPH formula for determining numbers and levels of staff. Staffing is then increased based on the needs of the resident population. A schedule is made on a monthly basis and reviewed on an ongoing basis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to follow policy procedures, failed to timely reorder medication, and failed to ensure that prescribed medication was available for one of four residents (R3) reviewed for medication administration. Findings include:On 5/11/26, IDPH (Illinois Department of Public Health) received allegations regarding medication administration.R3's diagnoses include sepsis. R3's (5/15/26) physician orders include Vancomycin 25mg (milligrams)/ml (milliliter) give 5 ml every 6 hours. R3's (4/10/26) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact).On 5/18/26 at 12:52pm, surveyor inquired about medication administration concerns at the facility R3 stated They (facility) didn't have my (R3) Vancomycin, they ran out of it. I (R3) finally got it today.R3's (May 2026) MAR (Medication Administration Record) affirms 9 (See Nurses Note) was documented on 5/17 at midnight, 6am, 12pm, and 6pm. 9 was also documented on 5/18 at midnight and 6am. R3's (5/17/26) progress notes state 1:35pm, Vancomycin: spoke with pharmacy, medication will be delivered with delivery today. 9:31pm, Vancomycin: awaiting pharmacy delivery. On 5/21/26 at 12:57pm, surveyor inquired about requirements for drug reordering V2 (Director of Nursing) responded With the antibiotic, we (staff) have to make sure the medication is on hand. You should reorder, call and alert the pharmacy when the medication is running low. Surveyor inquired what 9 indicates on the MAR V2 stated Other, see nurses note. Surveyor inquired about R3's 5/17/26-5/18/26 Vancomycin administration V2 reviewed R3's (May 2026) MAR and responded On the 17th, he (R3) has a 9 for midnight, 6am, 12pm, and 6pm. On the 18th he has a 9 for 12 midnight and 6am. Surveyor inquired if R3's Vancomycin was unavailable V2 reviewed R3's progress notes and replied This says at 9:31pm on 5/17 the nurse signed out that she was awaiting pharmacy to deliver. On 5/17 at 1:35pm, she did not have the medication available. Surveyor inquired how many doses of Vancomycin R3 didn't receive V2 stated I'm seeing 6 doses. On 5/26/26 at 11:21am, surveyor inquired what a blank entry on the MAR indicates V2 responded If it's not documented, it wasn't done.The medication administration policy (reviewed 10/2025) states if medication is ordered, but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication.The (January 2026) medication ordering and receiving from pharmacy policy states the refill order is called in, faxed, sent electronically or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label is pulled and transmitted to the pharmacy, when electronic ordering is unavailable.

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	05/27/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility failed to follow policy procedures, failed to follow physician orders, failed to administer medication as prescribed, and failed to ensure that four of four residents (R2, R3, R8, R9) reviewed for medication administration remained free from significant medication errors. Findings include:On 5/11/26, IDPH (Illinois Department of Public Health) received allegations that medications were not administered (as directed) at the facility.R3's diagnoses include sepsis. R3's (4/10/26) BIMS (Brief Interview Mental Status) determined a score of 13 (cognition intact).On 5/18/26 at 12:52pm, surveyor inquired about medication administration concerns at the facility R3 stated They (facility) didn't have my (R3) Vancomycin, they ran out of it. I (R3) finally got it today.R3's (5/15/26) POS (Physician Order Sheets) include Vancomycin 25mg (milligrams)/ml (milliliter) give 5 ml (milliliters) every 6 hours. R3's (May 2026) MAR (Medication Administration Record) affirms 9 (See Nurses Note) was documented on 5/17 at midnight, 6am, 12pm, and 6pm. 9 was also documented on 5/18 at midnight and 6am. R3's (5/17/26) progress notes state 1:35pm, Vancomycin: spoke with pharmacy, medication will be delivered with delivery today. 9:31pm, Vancomycin: awaiting pharmacy delivery. On 5/21/26 at 12:57pm, surveyor inquired what 9 indicates on the MAR V2 (Director of Nursing) stated Other, see nurses note. Surveyor inquired about R3's 5/17/26-5/18/26 Vancomycin administration V2 reviewed R3's (May 2026) MAR and responded On the 17th, he (R3) has a 9 for midnight, 6am, 12pm, and 6pm. On the 18th he has a 9 for 12 midnight and 6am. Surveyor inquired if R3's Vancomycin was unavailable V2 reviewed R3's progress notes and replied This says at 9:31pm on 5/17 the nurse signed out that she was awaiting pharmacy to deliver. On 5/17 at 1:35pm, she did not have the medication available. Surveyor inquired how many doses of Vancomycin R3 didn't receive V2 stated I'm (V2) seeing 6 doses. __R2's diagnoses include hypertension, epilepsy, and alcohol abuse. R2's (3/27/26) BIMS (Brief Interview Mental Status) determined a score of 14 (cognition intact).R2's progress notes state (5/10/26) 9:14pm, patient called 911 and went out. Nurse reported that she went as nurse did not arrive to room in time to give her medication.On 5/26/26 at 3:14pm, surveyor inquired why R2 called 911 (on 5/10/26) R2 stated I (R2) didn't get my pain meds or any other meds, nothing and affirmed this occurred on 3pm-11pm shift. R2's POS includes (8/9/23) Metoprolol Tartrate 25mg two times a day for hypertension, Topiramate 25mg at bedtime for epilepsy, and (1/3/26) Famotidine 20mg two times a day for Gerd (Gastroesophageal Reflux).R2's (May 2026) MAR affirms on 5/10/26 evening shift (blank) entries were noted for Famotidine (scheduled for 4pm administration), Metoprolol Tartrate (scheduled for 5pm administration), and Topiramate (scheduled for 9pm administration).On 5/26/26 at 11:21am, surveyor inquired what a blank entry on the MAR indicates V2 responded If it's not documented, it wasn't done.__R8's diagnoses include type II diabetes mellitus.R8's (4/16/26) BIMS determined a score of 14.R8's POS includes (7/16/25) Hydralazine HCL 50mg three times a day for hypertension and Metoprolol Tartrate 25mg two times a day for hypertension. (4/29/26) Gabapentin 100mg three times a day for neuropathy. (5/3/26) Lantus 100units/ml, inject 22 units at bedtime for diabetes mellitus. On 5/18/26 at 2:04pm, surveyor inquired if R8 has any medication administration concerns R8 responded No however R8's (5/10/26) MAR affirms (blank) entries were noted for Metoprolol Tartrate (scheduled for 5pm administration), gabapentin (scheduled for 5pm administration), Sucralfate (scheduled for 5pm & 9pm administration), Lantus (scheduled for 9pm administration), and Hydralazine (scheduled for 9pm administration). __R9's diagnoses include shortness of breath, chronic obstructive pulmonary disease and acute respiratory failure with hypoxia. R9's (4/24/26) BIMS determined a score of 15 (cognition intact).R9's (10/3/25) POS includes Advair Diskus Aerosol Powder (Corticosteroid) 250-50 micrograms/dose. 1 inhalation every 12 hours for decrease inflammation in lungs. On 5/26/26 at approximately 3:14pm, surveyor inquired about medication administration concerns at the facility R9 replied I (R9) have an inhaler I should get at 8:00pm, that's a problem.R9's (May 2026) MAR affirms (blank) entries were noted for Advair on 5/4, 5/5, and 5/10 at (continued on next page)

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	145419	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:00pm.The medication administration policy (revised 10/2025) states all medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. If medication is not given as ordered, document the reason on the MAR.