STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057950	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF ELMWOOD PARK	7733 WEST GRAND AVENUE , ELMWOOD PARK, Illinois, 60707

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S0000	Initial Comments Complaint Investigation: 2599501/2631755 2599246/2628813	S0000		12/12/2025
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.3240a) 300.3240b) 300.3240c) 300.3240g) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report	S9999		12/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These requirements were not met as evidenced by: Based on record review and interview the facility failed to follow policy procedures, failed to document a grievance form, failed to investigate reported theft of funds, and failed to report a theft allegation to IDPH (Illinois Department of Public Health) for one of three residents (R4) reviewed for misappropriation of funds. Findings include: On 9/26/25, IDPH (Illinois Department of Public Health) received allegations that roughly $500 of R4's SNAP (Supplemental Nutrition Assistance Program) benefits were stolen. The complainant feels it had to have been facility staff who had access to R4's social security number. The issue was reported but nothing was done by the facility. R4 was admitted to the facility on 12/30/24. On 11/20/25 at 10:38am, surveyor inquired about R4's stolen SNAP benefits V5 (Social Service Director) stated "She (R4) reported it to me (V5) over a year ago when she first admitted, it did not happen here (facility)." Surveyor inquired what was implemented when the allegation was received V5 responded "I (V5) told her (R4) we (staff) cannot help her with getting the money back. I told her to call the link card and see what they could do. She used to be with a roommate where she used to live (prior to admission) that had access to her (R4) card because it got shipped to her (roommate) address." Surveyor inquired where this information came from V5 stated "She's (R4) the one that told me (V5)." On 11/20/25 at 2:15pm, R4 stated "When I (R4) first got here (facility) I had SNAP benefits saved up and because I was brought here (facility), they (staff)	S9999		

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S9999	Continued from page 2 changed my address from my friend's house to this place (referring to facility). SNAP said they sent two letters, but the facility didn't give me those letters. What I was told when I called their (SNAP) number, is you can only order a new SNAP card if they have your social security number - the facility has access. They (unknown facility staff) stole $500 of benefits I had. (V5) said he (V5) investigated it, but I don't believe he did anything with it." Surveyor inquired if R4's roommate (prior to admission) had access to her snap benefit card (per V5's statement) R4 responded "No, my friend never had my card. My friend I was living with never would have done that, if that's what they're (staff) claiming I'm (R4) upset about that. The card was used in Chicago, she (friend) lived in Morris at the time." Surveyor inquired when the stolen SNAP benefits were reported to V5 R4 affirmed it was in "February." R4's (2/11/25) progress note affirms (roughly 6 weeks after admission) resident requested SS (Social Service) to discuss her link card. She wanted her card replaced; writer gave DHS (Department of Human Services) number to call. On 11/25/25 at 1:13pm, surveyor inquired about the facility policy for reported missing items and/or funds V5 (SSD) stated "We (staff) go talk to the resident and do a grievance form. If its money we go to the Administrator. Surveyor inquired (again) what was implemented when R4 reported stolen SNAP benefits V5 responded "I told my Administrator about that one because that's funds, that's money." Surveyor requested R4's (February 2025) grievance form at this time however it was not received. Surveyor inquired if IDPH was notified of R4's stolen SNAP benefits V2 (DON) affirmed that she would check with V1 (Administrator). On 11/25/25 at 1:23pm, V2 (DON) stated "I (V2) asked (V1/Administrator) if he did a reportable for missing snap benefits for her (R4), he (V1) said no." On 12/1/25 at 2:07pm, surveyor inquired about the facility policy for reported theft of funds V1 (Administrator) stated "If someone reported missing funds, we (staff) would have to do an investigation and report it, to IDPH." Surveyor inquired if R4's alleged stolen SNAP benefits was investigated V1 responded "The way it was explained at the time was that she (R4) wasn't a resident when they were missing and when she moved in here (facility) her (R4) benefits would have been canceled. So, no we (facility) did not report it because the way it was explained is that it happened prior to moving in the building." Surveyor inquired why	S9999		

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S9999	Continued from page 3 R4's theft allegation was not reported to IDPH V1 responded "Again, what was reported to me (V1) is 1) her (R4) benefits would have stopped already when she was admitted here and 2) it was reported that this happened prior to coming here." Surveyor inquired if V1 spoke with R4 about the stolen SNAP benefits V1 replied "No, I was going on the information that was brought to me that this was something that happened prior to being a resident here." Considering reasonable person concept, R4's (2/11/25) progress note, and resident/staff statements the facility was made aware of R4's link card concerns/theft of SNAP benefits - reported roughly 6 weeks after admission (not "when she first admitted" – as alleged) therefore funds were likely stolen sometime after admission. The facility abuse prevention policy (reviewed 9/2017) includes misappropriation of resident property: the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Reports will be documented and a record kept of the documentation. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 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 results of the investigation will be forwarded to the Illinois Department of Public Health within seven working days of the reported incident. The administrator or designee is also responsible for informing the resident or their representative of the results of the investigation and of any corrective action taken. (B) 2 of 2 300.610a) 300.1210a) 300.1210b)	S9999		

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S9999	Continued from page 4 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the	S9999		

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S9999	Continued from page 5 resident's medical record. These requirements were not met as evidenced by: Based on interview and record review the facility failed to follow policy procedures, failed to implement care plan interventions, failed to obtain vital signs, failed to conduct a thorough assessment, failed to fill out an SBAR (Situation Background Assessment Recommendation) form, and failed to ensure that EMS (Emergency Medical Services) was made aware of resident status/vital signs prior to arrival for one of three residents (R2) reviewed for change in condition. On 9/29/25, IDPH (Illinois Department of Public Health) received allegations that EMS was dispatched for sick, later upgraded to trouble breathing not recent – (R2's) feet were blue. (R2) was on oxygen, staff had little to no knowledge but said it was only a few minutes, it clearly had been longer that no one checked on R2 - not handled quick enough. R2 was 91 years old with diagnoses which include but not limited to COPD (Chronic Obstructive Pulmonary Disease), hypertensive heart disease with heart failure and peripheral vascular disease. R2's (6/10/24) care plan states resident has potential for difficulty in breathing related to COPD, intervention: observe for changes in breathing pattern. Monitor vital signs and lung sounds. R2's Physician Order Sheets include (10/21/24) Oxygen at 2 liters per minute per nasal cannula to maintain oxygen saturation readings between 90-96%. Oxygen saturation every shift for monitoring oxygen saturation readings. R2's (September 2025) Medication Administration Record affirms oxygen saturation ranged from 95-98%. R2's progress notes include (9/26/25) 10:35pm, writer observed resident breathing heavy checked oxygen 81%, nasal cannula was applied resident oxygen level raised to 91%. 911 was called and resident was transported to Hospital. Doctor was informed [liters of oxygen, respirations, blood pressure, pulse, temperature and lung sounds were excluded]. (9/27/25) Called and spoke to Nurse who stated that resident was intubated in ambulance by paramedics and is being admitted in Intensive Care Unit with shortness of breath, hypotensive, and is being given hypertensive medicines. (9/28/25) Contacted the hospital to inquire about resident status. Nurse informed that resident expired yesterday at 9:02am.	S9999		

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S9999	Continued from page 6 On 11/24/25 at 1:11pm, surveyor inquired about R2's (9/26/25) change in condition V7 (Licensed Practical Nurse) stated "I (V7) normally have her (R2) and I always check on my residents. She's (R2) always taking her nasal cannula off, when I walked in it was off and her breathing wasn't normal, she was breathing heavy. I put her nasal cannula on, and her oxygen level was low it was 91%. I don't know how long the cannula was off and didn't like the way she was breathing so I got an order from the doctor to send her out 911. Surveyor inquired how many liters of oxygen R2 was placed on prior to transfer V7 responded "I'm not even gonna guess I don't remember." Surveyor inquired how many liters of oxygen R2 was supposed to be on (per physician order) V7 affirmed she did not know. Surveyor inquired if R2's vital signs were obtained prior to transfer V7 replied, "The EMS I think they (EMS) did obtain her vital signs when they came, I can't remember. I'm pretty sure I did them because I have to give EMS the vital signs but again my nursing action was just send her out." Surveyor inquired where R2's vital signs were documented V7 stated "They would be documented in the Nurses notes." Surveyor inquired if R2's vital signs may have been documented elsewhere V7 responded "I'm not for certain, I can't recall. I just reacted and called 911." Surveyor inquired if R2's feet were blue prior to transfer V7 replied, "I looked at her whole body, and her feet wasn't blue. Surveyor inquired if R2 was breathing prior to EMS transfer V7 stated "Yes, she was." Surveyor inquired if EMS requested R2's status upon arrival. V7 responded, "I think they (EMS) asked me if she has COPD, but they didn't ask me anything else." R2's (9/26/25) "vital signs" documentation affirms at 1:40pm, blood pressure was 108/62, temperature was 97.8, pulse was 60, and respirations were 18. At 7:59pm, R2's oxygen saturation was 98%. No additional vital signs were documented (R2's change in condition occurred at 10:35pm). On 11/24/25 at 1:50pm, surveyor inquired about staff requirements for resident change in condition. V2 (Director of Nursing) stated, "They (staff) need to do an assessment and notify the doctor." Surveyor inquired what an "assessment" entails. V2 responded, "A head to toe assessment and vitals." Surveyor inquired where resident vital signs are documented. V2 replied, "In the chart." Surveyor inquired if V7 charted R2's vital signs on (9/26/25) V2 stated "I'm not really sure I do have to go back into the notes to see." V2 subsequently reviewed R2's (9/26/25) progress note and responded, "Not in this note, she (V7) didn't have any vital signs	S9999		

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S9999	Continued from page 7 in this particular note" (except oxygen saturation). Surveyor inquired how many minutes it usually takes for EMS to arrive to the facility when 911 is called V2 replied "It take em a couple of minutes to come here between 5 and 10 minutes they come rolling up." Surveyor inquired if V7 filled out an SBAR (which provides a structured framework for healthcare professionals to quickly and clearly share critical information about a patient, especially during handoffs) for R2's (9/26/25) change in condition V2 stated "I (V2) didn't see one." Surveyor inquired if an SBAR is supposed to be filled out for resident change in condition V2 responded "Yes, it is." On 11/15/25 at 11:13am, surveyor inquired about facility staff requirements for resident change in condition. V8 (Medical Director) stated, "I would expect them (staff) to get vitals and then contact the provider." Surveyor inquired which vital signs should be obtained for a resident experiencing respiratory distress. V8 responded, "The oxygen saturation, heart rate, blood pressure, all of them." Surveyor inquired if a resident is in respiratory distress which assessments should be conducted V8 replied "I would expect them to see if they're alert, diaphoretic, are they struggling using accessory muscles, listen to their lungs to see if they have wheezing, crackles, or no sounds at all." Surveyor inquired about potential harm to a resident if staff fail to obtain vital signs, fail to conduct a physical assessment and/or fail to report actual changes in condition to EMS and/or healthcare provider. V8 stated, "I guess increased mortality and morbidity." R1's Certificate of Death affirms death occurred on 9/27/25. The (9/26/25) facility change in resident condition policy states nursing will notify the resident's physician or nurse practitioner when: there is a significant change in the resident's physical, mental or emotional status [Physical Assessment, Vital Signs, and SBAR are excluded]. The facility Respiratory Care Monitoring policy (revised 10/2024) states any change in the resident's condition will be identified such as difficulty breathing, changes in color, change in mental status, or other changes that my signal further evaluation is needed. If the change requires immediate intervention (resident is in distress, having difficulty breathing) the assessment will be completed and appropriate interventions implemented. (B)	S9999		