STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint: 2196192/IL137483: F689G, F740G cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 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. (Section 3-202.2a of the Act) 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 resident's medical record. d) Pursuant to subsection (a), general	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 The plan shall be reviewed at least every three months. 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) These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to 1) monitor/supervise and provide a safe environment for a resident that was assessed to be intoxicated this affected 1 resident (R1) reviewed for monitoring/supervision. 2) develop an effective plan to modify the behavior of drinking alcohol, being intoxicated and displaying inappropriate behavior in the facility this affected 1 resident (R1) reviewed for behavior modification. These failures resulted in (R1) having multiple incidents of being intoxicated on the nursing unit and having peer to peer altercations. Subsequently leading to R1 falling to the floor after being assessed to be intoxicated, which resulted in R1 being sent to the local hospital and diagnosed with a frontal traumatic subarachnoid hemorrhage. The facility also failed 3) to implement a Resident's care plan to ensure that fall prevention interventions were in place to include call lights within reach and bed bolsters applied to prevent or reduce the risk of falling for 2 residents (R2, R7) reviewed for falls. These failure resulted in R2 falling on the floor next to the bed while attempting to reach for the call light to ask for assistance.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 Findings include: Record review for R1 documents a 63 year old male admitted to the facility on 9/17/2020. R1 diagnosis includes Atherosclerotic Heart Disease, long term use of Anticoagulants (blood thinner), Hemiparesis affecting right dominant side, Hypertension (high blood pressure), Anxiety Disorder, Cannabis Use. Current medications include: Warfarin (blood thinner) 10 mg daily, Enoxaparin (blood thinner) 0.7ml inject daily. On 9/1/2021 at 1:34 PM, observed R1 with a left black eye, blood shot sclera of the left eye, and a lump the size of a small grape on the left side of the left eye. R1 stated he fell last week. Progress notes for R1 documents the following: Note by V20 (PRSD, Psychiatric Recreational Social Director) : 8/23/2021 at 1:08 pm, Resident is noted under the influence of alcohol. Resident is noted smelling of alcohol and slurring of speech. Resident gait is unsteady. Resident refused the breathalyzer test. Resident refused to tell Administrator, APRSD (Assistant Psychiatric Recreational Social Director), MDS team, and writer the whereabouts of where he is keeping the alcohol and who is purchasing the alcohol. Note by V12 (APRSD): 8/23/2021 at 2:58 PM. This resident was placed on 1:1 due to exhibiting signs of intoxication. This resident was placed on 1:1 until ambulance arrived. This resident presented with belligerent behaviors, using socially inappropriate language, making threats to staff, attempting to antagonize staff by attempting to hit staff, then drawing his arm back.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 Note by V19 (LPN): 8/23/2021 at 8:52 PM. Resident returned back to the facility on gurney accompanied by two attendants. Resident escorted back to room and laid down for about two hours. Resident came out of room and began to curse at peers and staff. Resident threw a cup of water at this writer and then threw another plastic cup at this writer and stated that he would kill me when redirection was attempted. Resident attempted to enter peers rooms without permission and was redirected several times with resident cursing and threatening staff several times. Resident balled up his fist and attempted to hit this writer in the face. 911 was called and resident calmed down and went back to room. Wil continue to monitor resident. Note by V19 (LPN): 8/24/2021 at 8:03 PM. Resident fell in bed room hitting head and began to bleed with noted laceration above left eye. Pressure applied to laceration and steri-strips applied. 911 called to transfer resident to the nearest ER for evaluation. Resident left facility on gurney with eyes open talking to first responders in route to hospital. On 9/8/2021 at 9:02 AM, V19 (LPN) Stated she remembers the situation with R1 that occurred on 8/23/21 and 8/24/2021. V19 stated that R1 appeared intoxicated while we were waiting for hospital intake to accept him. R1 was on close monitoring by a CNA and myself. We redirected R1. R1 kept getting up out of bed, staggering and attempting to go into peer's rooms. He became verbally aggressive. R1 was threatening and threw cups of water at me and verbally threatened me. R1 was very verbally aggressive and approaching me in an aggressive manner. He kept stepping into my space. I was trying to keep a safe distance and he tried to hit me. He	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

threaten me several times. Police were called. We monitored him throughout the night after he came back from the hospital. I was doing rounds in the morning on 8/24/21 and noticed the curtain pulled. R1 "had fallen and he was still intoxicated, but verbally responsive. He had a laceration above his eye. His speech still slurred and still aggressive." I applied pressure to the laceration. Steri-strips and taped it. V19 stated she called the physician, and received orders to send R1 out and we placed R1 on neuro-checks.

On 9/9/2021 at 11:26 AM, V21 (Primary Care Physician) stated that if the R1 was aggressive he believes R1 should have had 1:1 monitoring to avoid injury.

R1's Hospital discharge instructions from 8/23/2021 21:04 (9:04PM) ER visit documents the following:
Diagnosis: Alcohol intoxication
R1 Hospital records document the following:
8/23/2021 at 16:30 (4:30pm); urine drug screen is positive for Cannabis
8/23/201 at 16:26 (4:36pm); Alcohol Level is 217H (217 High). {ClinlabNavigator.com document blood alcohol concentration of 150-300 mg/dl: Clinical signs & Symptoms = confusion, disorientation, impaired balance, slurred speech.}

R1 Hospital records from 8/24/2021 visit document the following:
Clinical Diagnoses: Fall; Hemorrhage of the Brain, traumatic; Acute Alcohol intoxication
CT Scan dated 8/24/21 documents the following:
Opinion: small acute subarachnoid hemorrhage (frontal brain bleed) within a left frontal sulcus.
Doctors History and Physical dated 8/24/21 documents the following: R1 "fell while intoxicated now has a SAH" (subarachnoid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 hemorrhage.) R2's fall risk care plan documents the following: 1) Be sure call light is within reach and encourage the resident to use for assistance as needed. Staff to respond promptly to all requests for assistance. Call light within reach among other interventions. 2) Staff to ensure the bed bolsters are securely fastened while in bed. 3) Sign put on wall to pull call light for assistance. 4) Sign put on wall to keep call light attached to shirt or pillow. 5) He has floor mats on both sides. On 9/2/2021 at 10:20 AM, Surveyor walked to R2's room which is next to the nurse's station. R2's call light is on. R2's door is wide open and he is on the floor screaming for help. Writer requested assistance from staff. V9 (RN) responded to call for help. R2 is observed next to the wall that runs parallel to his bed. R2 is wearing a ripped diaper, a shirt and no pants and black socks and shoes on. Surveyor asked R2 what happened. R2 stated "I was trying to get the call light. I'm wet." R2's call light is located on the wall and connected to light switch and is not within reach of the resident. The call light is behind and stuck under the bedside table. V9 was shown where the call light was located. V9 confirmed the call light placement, then with some difficultly V9 released the call light that was stuck under the bedside table. There were no bolsters or pads anywhere around the bed. There were no floor mats on the floor.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8 V9 stated he was the nurse caring for R2 today. Asked what kind of fall precautions are in place R2. V8 stated, " Just bed in low position. Some residents have pads on the floor. I don't recall him ever having any." On 9/2/2021 at 10:37 AM, V10 (CNA) stated he saw R2 about an hour ago and R2 gets in and out of the bed a lot. It was pointed out that there was not bed bolsters near the bed and requested to look in closet with V10. Bed bolsters were observed in R2's closet. V10 stated it is the CNA's responsibility to put the bed bolsters on the bed when resident is in bed. V10 states, "When I came this morning he was in bed and no bolsters were on the bed. I came in around 7:00 am. He had no bolster the whole morning." Post fall incident report for R2 by V19 (LPN) dated 9/2/2021 documents the following: "Resident Description: Resident stated he was attempting to turn on his call light by getting out of bed when he lost his balance resulting in a fall to the floor." On 9/7/21 at 9:05 AM with V18 (LPN). R2 is sleeping, No floor mats were noted on the floor. R7's Fall Risk care plan documents the following interventions: 1) Bed Low 2) Be sure call light is within reach and encourage the resident to use for assistance as needed. Staff to respond promptly to all requests for assistance. Call light within reach among other interventions. On 9/1/2021 at 12:50 PM, R7 observed sitting up in the bed and states she is not able to walk. Bed	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001143	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAR PLACE NURSING	6800 WEST JOLIET INDIAN HEAD PARK, IL 60525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9 not in low position. Observed call light was not within reach. Call light is 3-4 feet away from R7 hanging on a string that is not on the residents bed or close enough to reach. V4 (CNA) was asked if R7's call light is accessible. V4 stated that R7 moves her bed up and down frequently. R7 denies. Surveyor asked V4 how R7 reached her call light whether the bed is up or down. R7 started to roll her bed down and the call light was still too far away. V4 stated R7 can't reach it and attached call light on R7. On 9/7/21 at 9:09 AM, observed R7's bed is not in a low position. R7 is sitting up in her bed with R7's call light located to her right and behind R7 hanging from the wall. V18 (LPN) was asked how R7 can reach the call light. V18 stated it is usually on her. V18 pulled call light to the resident within reach. On 9/7/2021 at 12:23 PM with V18 (LPN) observed R7's bed to be in a very high position. Surveyor asked V18 about bed height. V18 stated she does not know why R7's bed is up so high. Facility's Fall Prevention Program document the following: Policy: It is the policy of this facility to have a fall prevention program to assure the safety of all resident in the facility, when possible. Standard Fall/Safety Precautions for All Residents: 8. Call lights are kept within reach and answered promptly. (A)	S9999		