| 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 04/16/2021 |

| 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<br><br>FRI of 3/12/21/IL132096 - F600G<br>FRI of 3/13/21/IL131965 - F689G | S 000 | | |
| S9999 | Final Observations<br><br>1) Statement of Licensure Violations:<br><br>300.610a)<br>300.690a)<br>300.690b)<br>300.1210b)<br>300.1210c)3)<br>300.1210d)6)<br>300.3240f)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.690 Incidents and Accidents<br><br>a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected | S9999 | **Attachment A**<br>**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 04/16/2021 |

| 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<br>outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.<br><br>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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:<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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.<br><br>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 04/16/2021 |

| 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 | S9999 | | |

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 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that staff protected a confused and dependent resident who was assessed as high risk for physical abuse from another resident with a history of aggression and with criminal felony background; they failed to ensure that resident (R1) was closely monitored after a previous history of threats of violence towards a former roommate; and they failed to ensure that staff provided supervision per facility

| 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 04/16/2021 |

| 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 | S9999 | | |

policy for two of four residents (R1, R2) reviewed for abuse. These failures resulted in R1's physical assault on R2 which required an emergent transfer to the hospital with the following injuries: facial trauma and head trauma, contusions to the face and head, lacerations to his head, face, and arms, eye socket fracture, and nose fracture.

Findings include:

R2 is a confused 75 year old with diagnoses of Parkinson's disease, Bipolar disorder without psychotic features, and protein calorie malnutrition. R2's most recent MDS (Minimum Data Set) dated 2/18/21, R2 requires extensive assist with most his activities of daily living and is unable to ambulate.

R1 is a 67 year old with diagnoses of dementia with behavioral disturbances, vascular dementia with behavioral disturbances, and schizophrenia. R1's MDS dated 2/9/21 shows R1 required only supervision in all his activities of daily living and was able to ambulate freely without any assistance from staff as he was also considered a wanderer and elopement risk.

Facility reported incident dated 3/12/21 submitted by V1 (Administrator) states in part (but not limited to): "On 3/6/21 facility staff observed R1 exiting his room. While redirecting R1 back into his room, R1's roommate, R2, was noted with injuries to his face. R1 and R2 were immediately separated, and R1 was placed on 1:1 with staff and separated from other residents. R1 stated that he responded to internal stimuli and believed he needed to protect himself. R1 then struck out at R2. While interviewing R1, he reported he was defending himself."

| 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 04/16/2021 |

| 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 | S9999 | | |

Interview with V4 (Social Service Director) on 3/29/21 at 11:40 AM stated, "This incident happened on a Saturday or Sunday so I was off. The administrator did the investigation but I did assist in it. (R1) and (R2) were roommates and I was told (R1) was agitated and sat on R2's bed and (R1) hit (R2) with his hands and fist. (R2) was injured I think and he was sent out to the hospital. (R1) is a new resident. I think he was admitted here in January but he has never threatened any other resident and he's pretty confused himself. Surveyor asked if R1 ever exhibited any other agitated or aggressive behavior towards any other residents, V4 stated, "No this was the only time."

Observations on 3/29/21 at 12:40 PM show R2 in bed but awake. R2 had 4 blackened circular shaped scabs above his forehead and his right eye was redddened and with yellowish tinge showing a previous healing black eye. Surveyor asked R2 if he remembered, what happened to him, R2 stated, "Roommate" but otherwise could not form complete sentences or coherent responses to questions.

Interview with V1 (Administrator) on 3/29/21 at 2:25 PM stated, "Everything is listed in the investigation I sent you. I did the investigation along with V4." Surveyor asked if there was any other incidents involving R1, V1 stated, "No that was the only one."

Review of facility records show however, on 1/26/2021 written by V5 (LPN) at 9:07 PM stated, "Behavior Charting Describe Behavior/Mood:: (R3)'s room mate (R1) is attempting to hit him with his belt, he is requesting a room change, he says I am afraid to sleep in the room.What was the resident doing prior to or at the time of

| 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 04/16/2021 |

| 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 | S9999 | | |

behavior/mood: unknown. Interventions attempted: to take the belt from him, resident keeps belt close at hand, resident also walks with belt in his hand.as if he he will hit you."

Further records show R1's agitated and aggressive behavior:

V6 (Social worker) wrote on 1/28/2021 at 11:26: "Resident has refused medication. Writer encouraged resident to take medication."
V4 (Social Service Director) wrote on 1/28/2021 3:07 PM "Resident petitioned out to the hospital due to exit seeking behavior. Resident continues to present with agitation and irritability. Resident currently on 1:1 with staff."
V7 (LPN) wrote on 2/4/2021 at 6:43AM, "Resident up in hall, verbally aggressive to staff, refusing to put his mask on, resident in non-re-directable."
V8 (LPN) wrote on 2/5/2021 at 6:07 AM, "Resident has been up since 1AM, confused, in and out of other residents room, taking their coats,shoes. Resident has been redirected to his room 8x and still continues to go in other residents room to pull their plugs out of their tv, cut their tv off, resident has woke up 5 other residents. resident will not stay with nurse, will not stay in room, just up walking around disturbing others."
V9 (LPN) 2/5/2021 at 9:45 pm, Nursing Progress Note Text: Resident medicated per protocol, ambulate per self, resident left 3rd floor to sleep on the 2nd floor. At the time he was on 3 rd floor, he was alert, oriented able to make needs known and denies pain or any discomfort."
V10 (RN) wrote on 2/10/2021 at 2:30 PM, "R1 is alert, disoriented, but can follow simple instructions. This shift, refusing care, (R1) needs supervision / cues for transfers, eating with supervision, dressing/hygiene with 1 assist."

| 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 04/16/2021 |

| 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 | | |

V5 wrote on 2/11/2021 at 12:20 AM, (R1) is alert, disoriented, and cannot follow simple instructions; has difficulty making needs known. This shift, refusing care."
V5 wrote on 2/12/2021 at 12:04 AM, "Room mate of this Individual just informed the nurse that urine was on the floor. Nurse immediately cleaned up urine from the walk way, from the 1st bed to the front of the bathroom."
V17 (Social worker) wrote on 2/14/2021 at 8:26 PM, "Resident showed signs of confusion by wandering and going through roommates personal belongings. Writer returned all belongings to roommates and resident apologized."

3/6/2021 at 6:58PM, V11 wrote, "Event Note. This resident (R1) is a 67 year old African American male. Resident has a diagnosis of unspecified dementia with behavioral disturbance, schizophrenia, unspecified vascular dementia with behavioral disturbance. Resident has a history with wandering due to diagnosis. Resident has a history with agitation and attempting to leave facility unauthorized. It was reported to the writer by the second floor nurse that this resident initiated a physical aggression on the second floor in peers room. Resident stated he does not know what writer is talking about, due to resident's diagnosis of dementia. Writer investigated immediately. It was reported to the writer that this resident wandered into peers room. Peer asked resident to leave, resident got agitated and pushed peer into the wall. residents were separated. Writer attempted to educate resident to seek the staff as needed. Writer attempted to encourage resident to refrain from aggression. Writer attempted to educate resident on deep breathing techniques to decrease agitation. V1 and V4 notified."

| 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 04/16/2021 |

| 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 | S9999 | | |

3/6/2021 at 10:16 PM, nursing progress note written by V15 (RN) stated, "(R2) Resident reported by CNA with blood on his face. Resident is alert, oriented x1, able to talk, no deviation in baseline level of consciousness noted. Assessment done, observed blunt wound on forehead and some bruising on right arm. First Aid done, cleansed area with normal saline solution, applied ice. Staff assisted resident in change of clothes. Dr. made aware, initially ordered resident to be sent out to hospital, then was informed that resident is going to another hospital via 911."

3/8/21 at 9:32 PM written by V14 (Nurse Practitioner) wrote: "PHYSICIAN PROGRESS: This patient (R2) was sent out to hospital on 3/6 for evaluation after he sustained multiple head wounds. Per Emergency Department records, the patient had brain CT scan with and without contrast. They were presumable negative since the patient was not admitted for observation. The patient has sutures on the outer Right eyebrow as well as scattered on the forehead and in the scalp. The patient has a Right eye contusion with a large amount of thick discharge from that eye. The lids are both swollen. the patient reports a headache but denies nausea, vomiting, change in vision, dizziness. Per nursing, the patient has had a good appetite since his return from hospital and sleeps ok during the night. The patient is quite alert today and answering questions appropriately. The patient had a Tetanus/dipheria in the Emergency Department and has been on Augmentin for prophylaxis related to multiple puncture wounds."

3/9/2021 at 7:13 AM, V16 (Wound Nurse) wrote, "Skin/Wound Note: Resident received from the

| 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 04/16/2021 |

| 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 | S9999 | | |

hospital on 3/7. Resident assessed by wound nurse. Resident has diagnosis from hospital of orbital fracture, open nasal fracture, and multiple lacerations to face and arms. Resident has 2 sutures to the forehead, 3 to the right eye. Eye is black, bruising to the nose. Resident has multiple bruising to the left and right arms. Skin tear to the right arm measuring 8.0 x1.5 centimeters. Treatment in place."

3/31/21 at 8:40 AM interview with V14 (Nurse Practitioner) stated, "I saw R2 after he came back from the hospital. I did write that he had sutures on the outer right eyebrow as well as scattered on the forehead and in the scalp. R2 had a right eye contusion with discharge. and both eyes were swollen." Surveyor asked about R2's puncture wounds on his head, V14 stated, "Oh yes, I remember seeing them. (R1) may have used some object to inflict those injuries because his hands alone can't make those puncture wounds on R2's head. He must have used some object." Surveyor asked V14 what her thoughts were on what the facility should have done to prevent this, V14 stated, "First of all I don't work for that company and I usually come in 4 days a week and see patients and I don't have anything to do with psychiatry. However, my opinion is that sometimes there are issues with patients that should have been placed in a different room or single room to themselves given their history. However, I do know that that the facility has had some issues with their private rooms due to their isolation needs. I do agree however, that if R1 had already had a history of violent behavior, he should have been monitored more closely and/or been provided a room by himself. I'm not sure why they would have moved him in with R2 who is very dependent."

| 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 04/16/2021 |

| 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 | S9999 | | |

R2's abuse risk assessment dated 6/6/2018 shows that R2 was at risk for physical abuse with risk factors that contributed to this risk as being serious mental illness, reduced social interactions, and frailty and total dependence due to his Parkinson's Disease. R2's only other abuse risk assessment was created on 3/6/2021, the day of his assault. This abuse risk assessment shows the same risk for physical abuse with an added description entry of "Resident received agression from peer."

Hospital records dated 3/6/21 show: "Assault victim, patient attacked by air mattress inflator (pump) per EMS.
75-year old male past medical history significant for Parkinson's disease, bipolar disorder who presents from prior place for an assault. Patient was attacked by another resident. He was reportedly hit in the face multiple times with an air mattress inflater (mechanical pump). Patient reports diffuse head pain. There's inconsistent reports as to loss of consciousness or the patient's neurologic baseline. Visit diagnoses: 1. Orbit Fracture, right (eye socket) 2. Laceration of face. 3. Open nasal fracture. 4. Contusion, Avulsion of skin"

4/1/21 at 9:06 AM, V1 (Administrator) was asked for their policy on supervision and/or if there was any flow sheet regarding the 1:1 supervision R1 was supposed to be receiving. V1 did not send any 1:1 supervision monitoring flow sheet nor policy requested. Surveyor clarified details about the incident when R2 was attacked, V1 stated, "When the incident occured on 3/6/21, I went into the facility to do my investigation. I interviewed staff and was not told there were any weapons involved or if R1 used anything to assault R2. I was told R2 was in bed at the time and when R1

| 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 04/16/2021 |

| 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 10 | S9999 | | |

came out of the room he was redirected back inside his room. This was when staff noticed R2 full of blood. His clothes was covered with blood and his bed was covered with blood. R2 cannot walk so he cannot get up from his bed without staff helping him. The staff cleaned him up and they sent (R2) out to the hospital." Surveyor asked again, if there were any other incidents involving R1, V1 stated, "Are you referring to when R1 threatened R3 with a belt?" Survyeyor then asked if there was an incident report pertaining to that incident, V1 responded, "No, I didn't consider that abuse as it was taken care of."

Facility policy dated January 4, 2019 titled "Abuse Prevention Program" states in part but not limited to: "This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or misappropriation of resident property or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offender ' s plan of care

| 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 04/16/2021 |

| 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 11<br>including the security measures listed.<br>Staff Supervision: Supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situations such as inappropriate language, insensitive handling or impersonal care will be corrected as they occur. Incidents that do not meet the definition of abuse, neglect mistreatment or misappropriation of resident property will be handled through counseling, training and, if necessary or repeated, the facility's progressive discipline policy.<br>Protection of Residents: Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The accused resident ' s condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility.<br>Internal Investigation 1. Incidents will be reviewed, investigated and documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected.<br>2. Incidents or allegations involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will be reviewed by administration and shall be investigated, as indicated and appropriate."<br><br>(A)<br><br>2) Statement of Licensure Violations:<br><br>300.610a) | 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 04/16/2021 |

| 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 12<br>300.1210b)<br>300.1210d)6)<br>300.1220b)2)3)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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:<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, | 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 04/16/2021 |

| 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 13<br>seven-day-a-week basis:<br><br>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.<br><br>Section 300.1220 Supervision of Nursing Services<br><br>b) The DON shall supervise and oversee the nursing services of the facility, including:<br><br>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.<br><br>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. The plan shall be reviewed at least every three months.<br><br>Section 300.3240 Abuse and Neglect | 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 04/16/2021 |

| 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 14<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Regulations were not met as evidenced by:<br><br>Based on interview and record review that facility failed to know when a resident had possession of a razor and failed to have an effective monitoring plan in place to prevent a resident from implementing any attempt to self-harm or possibly kill himself. This applies to one of one resident (R4) identified with a self- harming behavior. As a result, R4 who has a history of self-harm, took a razor and cut both his arms causing massive bleeding and had to be transferred to emergency for treatment.<br><br>Findings include:<br><br>R4 is a 44-year-old resident admitted to the facility on 10/19/2021. R4's diagnoses included but not limited to Schizoaffective Disorder, unspecified and Major Depressive disorder, recurrent. R4's social History and Assessment completed on 10/24/2019 indicated a problem with adjustment/mental health behavior issues with a self- harmful behavior.<br><br>According to an incident report 3/13/2021 at 6:50AM, R4 was observed with bleeding from forearms. Pressure dressing applied. 911 called and resident was transported to the local hospital. R5 (R4's roommate) alerted the facility nurse that R4 was in the washroom where R4 was noted to be bleeding. The facility nurse immediately went to the washroom where R4 was noted to have | 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 04/16/2021 |

| 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 15 | S9999 | | |

bleeding coming from bilateral upper forearms. Facility staff called 911 and R1 was transported to the local hospital where he received sutures to both sites. Upon R1's return to the facility, his care plans and assessments will be updated, and 72-hour follow up will be completed.

R4's social services notes dated 2/25/2021 at 1:37pm documented; The resident has acknowledged experiencing some anxiety due to infection control and safety practices and changes mandated by the CDC (center of disease), IDPH (Illinois Department Public Health) and CMS (Centers for Medicare and Medicaid Services).
R4's social services notes dated 2/25/2021 at 4:50pm documented; writer spoke with resident's psychologist V20 at the VA (veteran administration). V20 identified that resident has been presenting with increased behavior of paranoia and agitation.
R4's nurse's notes dated 2/26/2021 at 7:00am documented: resident observed having increased agitation and paranoia. Resident states he is bored and ready to go back to normal. Resident's behavior is being monitored every 15 minutes.
R4's social services notes dated 3/10/2021 documented; writer met with this resident to check well-being. R4 appeared anxious and withdrawn. This resident believes he overdosed on water and believes that he is going to hell.

04/07/21 at 1:30PM, R4 stated, he is a paranoid schizophrenic and a veteran. R4 stated he cut himself at the facility and does not know why. R4 stated he can't cope. While he was at the hospital the Chaplain told him, he was going to hell, so he cut himself at the hospital. He informed the facility about this incident. Facility had been monitoring and working with him regularly before he cut

| 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 04/16/2021 |

| 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 16 | S9999 | | |

himself, however he did not give them any indication that he was considering harming himself. The psych doctor never meets with him. He would like to see the psychiatrist and would also like to attend group therapy. R4 stated he has been feeling down. R4 stated part of the reason he feels down is due to isolation and being restricted to the facility and in his room as a result of COVID. Being able to walk around outside the facility would help him feel better. R4 stated the facility has offered him activities and music for psychosocial support. R4 stated he enjoys drinking a 6 pack of soda pop in one sitting.

On 4/07/2021 at 1:00PM, the surveyor asked V1 (administrator) how did R4 injury himself? V1 replied with a part of a remote control. The surveyor asked V1 was ever hospitalized for attempting to harm himself. V1 stated the last hospitalized was for hyponatremia. V1 was asked to present a timeline of how R4 was monitored the late night and earlier morning of the date of the incident for 3/13/2021.

The following information was given regarding a timeline of the incident: V7 (Licensed Practical Nurse/LPN) reported, at 11:55pm R4 in the room sleeping. V18 (certified nurse aide/CNA) reported, at 12:17am R4 was in the room laying across bed. V7 (LPN) reported, at 1am R4 was in bed sleeping. V18 reported at 2:30am R4 was pacing back in forth and came to nurse station for water. V7 reported, at 3:17am R4 came to the nurse's station to ask for water. V18 reported at 4:17am R4 was in his room on the bed. V7 reported at 5:15am R4 was in the bed not sure if he was sleep. V18 reported at 5:45am he was going into the room with a resident. R4 came out the room and went to the nurse station. V18 was

| 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 04/16/2021 |

| 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 17 | S9999 | | |

providing care to another resident. V7 reported at 6:20am, R5 (R4's roommate) came and asked for more water. He was told he had to be in his room, he was PUI (person under interest for COVID). Morning meds (medications) with water was given and he was told to keep his mask on. V7 reported at 6:50am while she was passing medication, R5 came and got her and said my roommate was in the bathroom for 10 minutes. I have to use it, I tried pushing the bathroom open and saw him on the floor. While the nurses were assisting the resident the battery cover of the remote was noticed.

On 4/13/2021 at 1:29PM, V7 reported R4 had been to the nursing station asking for water and asking what time it was. I gave him medication between 5:30-5:45 AM. I do my rounds every hour. R5 came to the nursing station and said his roommate was on the bathroom floor. I went to the room and saw blood on the floor. I saw R4 on the floor and I though he may have fallen but I saw the blood coming from his arm. I yelled out for help. Another nurse came to help me put the pressure bandage on the wounds. The surveyor asked V7 to describe the wounds. V7 stated the cuts were deep but she didn't measure them because she was wrapping the resident's arms. The surveyor asked V7 was there much blood? V7 said it was blood in the sink and over the floor. The surveyor asked what did R4 cut himself with? V7 all I could see because the police came, and search was a screw from an electronic device. The surveyor asked V7 if she documented in the resident's medical record would be an accurate account of what happen on 3/13/2021 involving R4's incident? V7 respond, Yes.

Two entries were noted in R4's medical records written by V7 as follows: 3/31/2021 6:50am, This

| 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 04/16/2021 |

| 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 18 | S9999 | | |

writer was called to his room per roommate stating My roommate is on the floor there is some blood. Resident observed on the floor with cuts to both inner arms, pressure dressing applied. 911 on scene. Administrator made aware. 3/13/2021 at 6:50am, R5 came to nurse's station to inform writer that his roommate had been in bathroom for a few minutes. I attempted to open door and observed resident laying on the floor with blood. This writer went immediately to room and observed resident laying on the floor bleeding from both arms, pressure dressing applied and 911 was called. Police and 911 on scene administrator made aware. Resident transferred to hospital.

On 4/13/2021 at 2:54PM, V11 (social worker/ PRSC) was asked by the surveyor how did R4 injure himself on 3/13/2021? V11 stated, she talked with R4 after he was readmitted and R4 told her he used a razor.

R4's physician progress note completed by nurse practitioner dated 3/31/2021 at 11:32am documented; Patient seen in his room, patient was recently hospitalized for slitting forearms with razor, no surgery was needed ...

Local hospital emergency room records for R4's visit 3/13/2021 indicated: Chief Complaint: Pt (patient) was brought in by EMS (emergency medical service) from the facility for a suicide attempt. Pt cut both wrists and was found unresponsive on the floor. EMS stated CPR due to difficulty feeling pulse. Pt has a pulse upon arrival and CPR was discontinued on route. HPI (History Physical Information): 43-year-old with history of schizoaffective disorder and recurrent visits due to SI (suicidal ideations). Per EMS he was found on the floor with bilateral wrist

| 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 04/16/2021 |

| 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 19 | S9999 | | |

lacerated and about 100-200 ml (milliliters) of blood on the floor per the paramedic estimates. ED (emergency department) Course documented: Pt communicated to RN (registered nurse) staff, disappointment on "not going to the light and will continue to try until I see it." He (R4) also admitted to me he has chronically been wanting to kill himself "I drink a lot of water and I won't stop until I see the light." Pt has history of becoming hyponatremia and being hospitalized due to excessive free water intake. Procedure Note: Laceration Repair- Description of wounds: 16 cm (centimeters) complex linear wound. The wound was reapproximated in two layers utilizing #29 sutures.

The EMS run sheet contained the following information about R4: Dispatched to above location (facility address) for the psychiatric evaluation. Arrived on scene and saw PD (police department) on scene running back into building with an AED (automated external defibrillator). Initial contact with our 43-year-old male pt. (patient) lying down outside of the bathroom unresponsive covered in blood. Staff does not know how long pt. is down for. They bandaged and have bleeding controlled on both wrists which have bilateral lacerations deep to the tendon and approx. (approximately) 4 inches. Bathroom floor has approx. 200mL (milliliters) of blood present and it has started to clot. A razor was found in the trash.

On return to the facility on 3/30/2021 the following was noted among the hospital's records upon transfer: Behavioral Health Department for a local hospital dated 3/25/2021 had instruction to keep the resident safe including but not limited to removing harmful objects.

| 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 04/16/2021 |

| 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 20<br><br>R4's comprehensive care plan with the date of 10/30/2019 & revision date 4/08/2021 contained the following information: R4 has history of suicidal ideation and attempt. R4 was hospitalized of suicidal ideation/gestures. R4 identified has triggers and stressors as stress and COVID-19. R4's warning sign are also note when he becomes angry, yells or shuts down. Inventions included the following: Educate the resident on coping skills he can utilize when feeling depressed, Initiated 10/30/2019. Provide resident with 1:1 support when experiencing heightened depression, Initiated 10/30/2019. Provide resident with psychotropic medication as prescribed. Initiated 10/30/2019. Resident was provided a picture of his niece to place in his room as a protective factor for self-harm, Initiated 04/08/2021. Resident will be placed on behavior monitoring to assess for suicide behaviors and gestures, initiated 3/30/2021. Resident will call family such as his sister or father when feeling down or depressed, Initiated on 4/08/2021.<br><br>There was no comprehensive plan for monitoring R4 for self-injury behaviors prior to his incident of 3/13/2021 when the resident had a documented increase agitation starting 2/26/2021. It also, does not identify how R4 injured himself and lead to his last hospitalization. In addition, the care plan does not address R4's behavior of excessive water intake to harm himself.<br><br>(A) | S9999 | | |