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 _____	09/29/2022

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

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S 000	Initial Comments Annual Health & Complaint 2297301/IL151140	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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: 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. These Regulations were not met as evidenced by Based on interviews and record reviews, the facility failed to have adequate supervision and interventions in place to keep residents assessed to be at risk for falls, free from injury. These failures applied to two (R133 and R302) residents reviewed for accidents and supervision and resulted in 1) R133 having a fall with head injury that required three sutures and resulted in 2) R302 having an accident which resulted in a mid-collar bone fracture. Findings include: R133 is a 72-year-old male who was admitted to the facility 1/27/22 with diagnoses that include Dementia, cognitive communication deficit, lack of coordination and anxiety disorder. According to Minimum Data Set Assessment dated 8/21/22,	S9999		

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S9999	Continued From page 2 R133 has a BIMS of 03 indicating significant cognitive dysfunction. R133 also has a functional status requiring supervision by staff for walking. Fall incident report dated 9/23/22 indicated that R133 lost his balance and fell on his left side while trying to walk the hallway. R133 sustained a bleeding injury to the back of the head, was in visible pain and was sent to the local hospital for evaluation. R133 returned to the facility with 3 staples to the back of the scalp. On 09/27/22 at 11:25 AM R133 was observed in a reclining chair in front of the nurses station. R133 moved legs over the arm of the chair and got out of the chair standing. Two staff rushed to put R133 back in the chair. At 12:15 PM V7 (LPN) said, R133 is a fall risk and he keeps getting up. He recently had a fall I believe Friday or Saturday. He had to go to the hospital and came back with three staples to the back of his head from a laceration. He is able to walk, and he sometimes goes into other rooms to walk because he has bad dementia. 09/29/22 11:11 AM V3 DON (Director of Nursing) said, I'm not sure if R133 has fallen in the past. I would not have expected the nursing staff to leave him unsupervised. Usually on the second floor the CNAs are doing a lot, so sometimes they put residents at the nursing station for close supervision. I would expect for the staff to always watch the residents while sitting at the nurse's station. On 9/29/22 at 10:11 AM V1 Administrator said, I am still investigating the incident. What I understand is that he slept most of the day, woke up sometime in the evening went out into the	S9999		

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S9999	Continued From page 3	S9999		

hallway and ended up falling. He came out of his room and was walking with socks on and no shoes.

On 09/29/22 at 10:52 AM V33 Assistant Director of Social Services said, at the time R133 fell, R133 was moved to a different room because we were rearranging for isolation. While the CNAs were preparing his room and bed, he was in a chair outside of the room. I was pushing a resident in the wheelchair to in the hallway when I saw him fall. It was noticed that R133 was weaker than normal because he was having trouble walking and not at baseline. He also has dementia and doesn't know what's going on most of the time. I saw him falling slow motion and was pushing another resident so I couldn't get to him fast enough to prevent him from falling. We were just walking by and staff were busy doing other things. There was no other staff in the immediate area to assist and prevent him from falling. He fell and hit the back of his head with some bleeding. The CNAs helped him back to the chair and called the nurse.
Care plan for falls initiated 5/17/22 and updated 9/26/22 states in part that R133 is at risk for falls related to comorbidities including antianxiety, dementia and lack of coordination. Interventions reviewed. Facility Fall policy reviewed which states in part, Footwear will be monitored to ensure the resident has proper fitting shoes or footwear is non-skid.

R302 is a 90-year-old female with a diagnoses history upon admission 05/23/3033 of Dementia with Behavioral Disturbance, Multiple Fractures, History of Falling, and Vertigo.

R302's admission fall assessment dated 05/23/2022 documents she was at low risk for

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S9999	Continued From page 4 falls with a score of 1.0. R302's admission referral packet dated 05/12/2022 documents she had a history of falls and fractures, fell in the bathroom while at home, exhibited increased restlessness and agitation. R302's most current care plan for falls initiated 05/24/2022 documents she is at risk for falls related to Poly-pharmacy, History of Falls, Cognitive Impairments, Communication Impairment, Decreased Safety Awareness, Impulsiveness with attempts to stand or self-transfer without assistance from staff despite repeated direction/education, Use of Psychotropic Medications, Behavioral Problems, vertigo diagnosis with interventions including: Anticipate and meet individual needs of the resident, complete the Fall Risk Review per the facility protocol. R302's admission Minimum Data Set dated 06/03/2022 documents that she required supervision and one-person physical assistance with transfers, movements inside and outside the room, toilet use and requires limited one person physical assistance with walking in room, walking on and off unit, dressing, personal hygiene, and walking in corridors; was always incontinent of bowel and bladder. R302's initial incident investigation report dated 09/12/2022 documents R302 experienced an injury as a result of stumbling while on her way to the washroom in her room and bumping her arm on the door. R302 and her roommate denied that she had fallen. R302 had reported to the nurse that she was having right shoulder pain; a body assessment was conducted, and she was noted with bruising to her right collar bone. An x-ray was	S9999		

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completed and revealed R302 with a fracture to the mid collar bone and noted she had a history of a fracture to the right collar bone with hardware in place. R302 was sent to the hospital and upon her return care plans and assessments will be updated. The root cause is an accident caused by stumbling into the door frame and there was no credible evidence of abuse; V40 (Licensed Practical Nurse) was interviewed and stated she went to R302's room after receiving a report from V41 (Certified Nursing Assistant) that R302 had a bruise on her shoulder and observed R302 with a bruise. V40 reported R302 told her she bumped her arm on the door when she got up from bed and transferred herself into the wheelchair and she rolled toward the door; once at the door she stood up and showed how R302 hit the door and the bruise matched up with the edge of the door.

R302's progress note created by V40 (Licensed Practical Nurse) dated 9/11/2022 18:38 documents CNA reported to writer that resident has a bruise to right shoulder. Writer asked what happened and she stated that she bumped her shoulder on the bathroom door handle while ambulating. Writer measured resident up to the door handle. The door handle is the approximate height to resident shoulder. Resident complained of pain rating at a 5. Writer received a telephone order for a stat X-Ray of the right shoulder.

On 09/29/22 at 9:51 AM V1 (Administrator/RN) stated the facility initiates a fall assessment during the admission process, a referral packet is reviewed for history of falls and care plan is updated with interventions. V1 stated R302's current care plan does not reflect a root cause analysis or personalized interventions based on past falls. V1 stated although R302's incident was not a fall it was an accident. V1 stated stumbling

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from one plane to the next such as what occurred during R302's incident is an example of a risk factor for falling. V1 stated staff reported R302 walked independently and would need some redirection but she was alert and could answer and voice her needs. V1 stated based on R302's current care plan she was at risk for the incident she experienced. V1 stated there should have been more interventions in place for R302. V1 stated care plans should be personalized.

09/29/22 04:15 PM V1 (Administrator) stated R302's fall risk interventions could have included 15-30 minute checks and being placed closer to the nurses station for closer supervision.

The facility's Care Plan Policy reviewed 09/29/2022 states:
"All residents will have comprehensive assessments and an individualized plan of care developed to assist them in achieving and maintaining their optimal status."
"The interdisciplinary team develops a comprehensive, individualized care plan based on interdisciplinary team assessments and comprehensive assessment of the resident prior to the care conference" within 21 days of admission.
"Concerns, problems, needs, and/or strengths are listed based on resident's individual needs. Physician's orders and personal care and nursing needs are also listed based upon comprehensive assessments."

The facility's Fall Prevention Program Policy reviewed 09/29/2022 states:
"It is the policy of this facility to have a fall prevention program to assure the safety of all residents in the facility, when possible. The program will include measures which determine

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S9999	Continued From page 7 the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary." "The Fall Prevention Program includes the following components: Use and implementation of professional standards of practice Care plan incorporates: Preventative measures." "All assigned nursing personnel are responsible for ensuring ongoing precautions are put in place and consistently maintained." "Residents at risk of falling will be assisted with toileting needs in accordance with voiding patterns identified during the assessment process and as addressed on the plan of care." (B)	S9999		