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 02/28/2020

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 investigation 2091186/120144 - F689 G	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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	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 02/28/2020

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	S9999		

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidence by:

Based on interview and record review, the facility failed to provide supervision to prevent residents from becoming involved in a physical altercation. This failure resulted in one of three residents (R4) sustaining a right hip fracture and bruising to the right side of the head in a total sample of 11 reviewed for supervision.

Findings include:

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 02/28/2020

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		

R4 has the following diagnoses: delusional disorder and unsteady gait. R7 has schizoaffective disorder bipolar type.

On 02/21/2020 at 2:55PM, R4 was unable to recall the incident that happened with R7. R4 is not cognitively aware to answer questions.

On 02/25/2020, R7 stated, I was getting ready to smoke and V13 (Laundry Aide) grabbed me a chair to sit down. R4 wanted the chair and put her hand on my face. R4 cussed at me. I tried to block her and I pushed her and she fell to the floor. R4 put her hands in my face very quickly, staff could not get to her.

Incident report dated 1/20/2020, notes R7 was sitting in a chair near the beauty shop awaiting smoke break. R4 observed R7 sitting in a chair and proceeded over to take the chair. R7 declined to give R4 the chair and R4 reached into R7's face. R7 pushed R4 and she fell to the floor. R4 has a diagnosis of unsteady gait, which makes it easier for R4 to fall. Witnesses report that R7 was defending herself and did not use a great deal of force during this event. R4 and R7 were separated. R4 was sent to a local hospital and was diagnosed with a right hip fracture. R4 stated that she was trying to get the chair at that time and she was pushed to the floor.

Progress note dated 1/15/2020, notes that R4 was involved in an altercation with R7. R4 was unable to bear weight on her lower extremities, complained of pain to the entire right side of her body, and a contusion noted on the right side of her head.

On 02/25/2020, at 12:41PM, V11 (Social Services

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 02/28/2020

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		

Assistant) stated, I was coming down to the basement to help with smoke break. I saw R7 push R4. R4 had grabbed R7's face. I cannot recall the staff that was there.

On 02/25/2020, at 1:29PM, V13 (Laundry Aide) stated, there was a chair in the hallway. I moved the chair for R7. I turned and walked away. Somehow R4 and R7 got into an altercation. I heard commotion. I turned around and R4 was on the floor. It was smoking time and I could not see any staff. There is usually a smoking monitor, but I could not recall who it was.

On 02/25/2020, at 2:12PM, R8 stated, it was smoking time. It was crowded as always. R7 was sitting in a chair and got up. R4 tried to get the chair and pushed R7 in the face. R7 pushed R4. I am not sure who the smoke monitor was.

On 02/25/2020, at 2:16PM, R9 stated, R4 got into R7's face and was trying to hit R7. R7 pushed R4 and she fell. Staff is usually outside of the smoking room, handing out cigarettes, not on the inside of the room. There was no staff in the room. It happened so fast. R4 has an anger issue.

On 02/26/2020, at 1:21PM, V2 (Director of Nursing) stated, there are psychiatric residents in this facility. Their behaviors can go from one extreme to the other. Residents could fly off of the handle at any moment. Staff are responsible to keep order; that no fighting occurs. There are some areas where residents cannot be supervised. It is unacceptable that this happened and it should not be occurring.

R4's care plan documents to observe frequently and place in supervised area when she is out 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 02/28/2020

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		

bed. R4 demonstrates behavioral distress and has a history of physical aggression towards others.

R7's care plan notes R7 is at risk for aggressive behavior, poor impulse control, anger/hostility, and has a history of hitting other residents.

Ambulance documentation dated 1/15/2020, noted that the ambulance was dispatched to the nursing facility. Upon assessment, R4 was noted to have a head injury; hematoma (bruising) to the right side of her head and pain to her right hip and femur (lower leg) area.

Medical records dated 1/15/2020, note R4 was in a fight at the nursing facility. R4 has a confirmed right hip fracture.

(B)