STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0054841**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/11/2025**

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

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S0000	Initial Comments ANNUAL LICENSURE SURVEY	S0000		09/19/2025
S9999	Final Observations 1 of 2 Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		09/19/2025

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

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S9999	Continued from page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to protect three residents (R14, R127, R195) from abuse. This failure resulted in R14 sustaining a reddened area to chest and experiencing pain, and R127 experiencing psychosocial harm. This failure affected three residents (R14, R127, R195) out of 72 residents reviewed for abuse. Findings include: On 9/8/2025 at 12:06 PM, during lunch observation, surveyor observed R48 pick up R48's lunch tray, yell and struck R14 in the chest with the lunch tray. R14 yelled out and backed away from R48. R48 then threw the lunch tray across the room, hitting R195 in the shoulder. R48 attempted to move towards R14 when V15 (Certified Nursing Assistant) and V16 (Certified Nursing Assistant) intervened and separated the residents. V15 and V16 denied that they saw the incident as they were passing trays. Surveyor attempted to interview R48, but R48 was unable to be interviewed due to cognitive impairment. R14 went to R14's table and stated, "I don't know what happened, (R48) just came up to me and hit me with (R48's) tray. I am in some pain, I would say like 5 out of 10". R14 lifted his shirt and showed surveyor a reddened area approximately 2 inches in diameter under R14's nipple. R14 stated that he doesn't really feel safe residing in the facility after this incident. On 9/8/2025 at 12:10 PM, R195 affirmed that R195 saw R14 get hit with the lunch tray. R195 stated, "I was sitting here, and the tray was thrown at me and hit me in the shoulder. My pain isn't that bad, maybe 2/10". R190, R50, and R91 were sitting at R195's table during the interview and affirmed they saw R14 get hit by R48 and that R195 got hit by the tray thrown by R48. Additionally, R186, R12, and R143 were sitting at the table next to R195 and affirmed they saw R48 hit R14 with the lunch tray and affirmed they observed R195 get hit with the lunch tray. On 9/10/2025 at 3:22 PM, V1 (Administrator) affirmed that V1 is the abuse prevention coordinator for the	S9999		

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S9999	Continued from page 2 facility. V1 described physical abuse as unwanted contact, hitting someone or fighting. V1 affirmed that all residents have the right to be free from abuse. On 9/11/2025 at 11:10 AM, surveyor observed R137 sitting in a wheelchair then grabbed R127 by the shirt, pulling R127 down towards R137. R137 began yelling in a threatening manner at R127 stating, “You better never ever f***** come in my f***** room again, takin my s***!! Stay out my room!”. V20 (housekeeping/laundry supervisor) was nearby and intervened and separated the residents. V20 affirmed that R137 grabbed R127 by the shirt and was yelling at R137, telling him to stay out of his room. On 9/11/2025 at 11:14 AM, R137 was observed in R137’s room and stated, “Yeah, I did grab (R127). (R127) is always comin’ in my room and takin my s***. I am tired of it. They (facility staff) know (R127) always up in my business. If they (facility staff) not gonna do something about it, I will!!”. On 9/11/2025 at 11:15 AM, R127 was sitting at a table in the dining room and was unable to be interviewed due to cognitive deficits (word salad responses). Applying the reasonable person concept, a reasonable person would have been fearful of R137’s actions of forcibly grabbing their shirt, pulling them down and aggressively yelling at them. On 9/11/2025 at 2:58 PM, V34 (Psychiatrist) affirmed that V34 was a psychiatrist on staff at the facility. V34 affirmed that R127 is severely cognitively impaired from overlapping diagnoses of schizophrenia and dementia. V34 explained that responses to abuse can vary from person to person and can cause fear or other psychiatric symptoms. V34 affirmed that residents have the right to be free from abuse in the nursing home setting. Facility policy titled, “Abuse Prevention Program” (1/2024) documents in part, “Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment… Abuse if defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish… instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled though the use of technology. Willful, as used in this definition of abuse, means the individual must have acted	S9999		

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S9999	Continued from page 3 deliberately, not that the individual must have intended to inflict injury or harm…" B 2 of 2 STATEMENT OF LICENSURE FINDINGS: 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. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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	S9999		

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S9999	Continued from page 4 receives adequate supervision and assistance to prevent accidents. THESE REQUIREMENTS WERE NOT MET EVIDENCED BY: Based on observation, interview, and record review, the facility failed to provide appropriate footwear as a fall prevention intervention for a resident (R86) who was at risk for falls; failed to accurately complete the fall risk assessment for R39; and failed to ensure that resident (R39) was closely supervised to prevent frequent repeated falls. These failures resulted in R39 having thirteen repeated falls within six months, four out of the thirteen falls resulted in transfer to the hospital, and one resulted in a fracture of nasal bones. These failures affected two residents (R39 and R86), out of 72 residents reviewed for falls and fall prevention interventions. Findings include: On 9/8/25 between 11:15am and 11:35am, R39 was observed in the room and later went to the hallway. No staff supervision observed. R39's records of fall incidents presented by V2 (Director of Nursing) show that R39 had 13 repeated unwitnessed falls as dated below: 3/5/25 12:00AM - unwitnessed 3/18/25 1:00PM -unwitnessed 4/25/25 12:30PM -unwitnessed 5/2/25 7:46AM- unwitnessed fall- Sent to the Hospital 5/7/25 11:30AM- unwitnessed 5/10/25 6:00PM -unwitnessed – Sent to the Hospital – Diagnoses- Head Injury and laceration. 5/22/25 2:45AM -unwitnessed 6/4/25 7:00PM -unwitnessed 6/24/25 7:26PM -unwitnessed 7/19/25 5:15PM -unwitnessed 7/30/25 3:45PM- unwitnessed 8/7/25 10:30AM- unwitnessed – Sent to the Hospital	S9999		

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S9999	Continued from page 5 -Diagnoses -Fracture of Nasal Bones, possible need for Plastic Surgery. 9/10/25 8:00AM- unwitnessed - Sent to the Hospital – Diagnoses -Fall, Head Injury, Laceration of Scalp. Hospital Records of the 8/7/25's fall with injury dated 8/8/25 written by the Hospital Physician states in part: CT imaging shows acute chronic nasal bone fractures. He is stable for discharge back to the nursing facility and can follow up with plastic surgery regarding his nasal bone fracture. Hospital Records of the 9/10/25's fall with injury dated 9/10/25 written by the Hospital Physician states: Final Diagnoses – Fall, Closed Head Injury, and Laceration of Scalp. Hospital Records of the 5/10/25's fall with injury dated 5/10/25 written by the Hospital Physician states in part: Indication – Head Injury, Laceration; Headache after Trauma. R39's records show the following: Fall Risk Review dated 9/10/25 shows that R39 is at risk for falls. History of falls within the last 3 months states 1-2 falls, but records show that R39 had 5 falls between 6/10/25 and 9/10/25. On 9/11/25 at 2:18pm, the surveyor asked V2 why the Fall Risk Assessment stated that R39 had only 1-2 falls in the past 3 months when R39 actually had five falls in the past 3 months. V2 responded, it's possible that the floor nurse who did the assessment made a mistake in the assessment. Face sheet shows diagnoses which include but are not limited to Osteoarthritis, Pain in The Leg, Schizoaffective Disorder, and Fracture of Nasal Bones (dated 8/9/2025). Care plan dated 11/11/22 and 5/17/25 state that R39 is at risk for falls. Intervention states in part to anticipate and meet individual needs of the resident, and to complete the fall risk review per facility protocol. MDS (Minimum Data Status) Section GG dated 7/28/25 states that R39 requires supervision/touch assistance (code 04) for functional abilities. No staff was observed supervising R39. On 9/8/25 at 10:50am, R86 was observed sitting in the	S9999		

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S9999	Continued from page 6 wheelchair in the dining room with a pair of black/white socks with smooth bottom (not non-skid). Again, 0n 9/8/25 at 11:55am, R86 was still in the wheelchair with the same pair of socks. At this time, V10 (Restorative Nurse) was called to the dining room and asked if R86 should have nonskid socks. V10 stated, R86 could be a fall risk, and she (V10) would find nonskid socks for R86. R86's records reviewed are as follows: Face sheet shows diagnoses which include but are not limited to History of Falling, Dementia, and Abnormal Posture. Fall Risk Review dated 1/10/25 shows that R86 is at risk for falls and #3 states that R86 had 1-2 falls within the last 3 months. Care plan dated 2/9/2018 and 1/2/2025 state that R86 is at risk for falls related to poor coordination, general weakness, unsteady gait, and history of falls. Intervention states to provide Non-skid slipper socks. BIMS Score is 6 out of 15 (Severe Cognitive Impairment). MDS section GG dated 8/13/25 states that R86 needs partial/assistance (03) to substantial/maximal assistance (02) for mobility/functional ability. On 9/9/25 at 2:10pm, V2 stated that the Restorative Nurse (V10) is in charge of falls, but she (V2) oversees falls. On 9/11/25 at 2:15pm, V2 stated, staff should follow the care plan for all residents at risk for falls, and that the Restorative Nurse did not inform her (V2) about R86 who did not have non-skid footwear. On 9/11/25 at 3:58pm, V35 (Nurse Practitioner) was interviewed regarding R39's frequent falls and why closer supervision and following fall prevention interventions was needed for R39 and other residents at risk for falls. V35 stated, R39 was recently moved to the second floor closer to the nursing station. V35 added that the second floor has more staff to supervise residents more closely. V35 explained that R39 does not know his physical limitation and does not ask for help. Facility's Policy and Procedure on Safety and Supervision of Residents dated 3/2025 states in part: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are	S9999		

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S9999	Continued from page 7 facility wide priorities. #4 states in part: Implementing interventions to reduce accidents risk and hazards may include the following (b) Assigning responsibility for carrying out interventions; (d) Ensuring that interventions are implemented. #2: Resident supervision is a core component of the systems approach to safety. B	S9999		