STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145784	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briar Place Nursing	6800 West Joliet Indian Head Park, IL 60525

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34072 Based on interviews and record reviews, the facility failed to follow its self-administration of medications policy and assess one resident (R17) to determine if this practice was safe prior to allowing R17 to self-administer medications out of three residents reviewed for self-administration of medications in a sample of 35. Findings include: On 3/21/24 at 11:30 AM, V26 (Nurse) stated that residents that are alert and oriented x 3 are able to self-administer medications. V26 stated that V26 gave the prescribed hemorrhoid ointment to R17 and R17 would self-administer. V26 denied monitoring R17 while R17 self-administered this medication to ensure medication administered as prescribed. On 3/21/24 at 3:00 PM, V2 DON (Director of Nursing) stated that no resident at this facility can self-administer medications. V2 stated that residents have to be assessed and cleared from physician's standpoint before they could take medications on their own. V2 stated that R17 would not be appropriate to self-administer medications. On 3/22/24 at 2:30 PM, V10 LPN (Licensed Practical Nurse) stated that the resident can self-administer medications if he/she has a physician order. V10 identified her initials on R17's September MAR (medication administration record) and stated that she was assigned to provide care for R17 on 9/12, 9/13, and 9/14. V10 stated that she does not recall if she administered the medication to R17 or observed R17 inserting the hemorrhoidal medication into his rectum. R17's medical record does not note R17 was assessed by the interdisciplinary team and determined safe to self-administer hemorrhoid ointment. There is no documentation noting R17 had a care plan for self-administering medications. This facility's self-administration of medications policy, dated 09/2020, notes residents have the right to self-administer their medications if they have the cognitive, physical and visual ability and the interdisciplinary team has determined the practice is safe for the resident. Residents who request to self-administer drugs will be assessed at the time of admission or thereafter, to determine if the practice is safe. The assessments will be discussed with the attending physician and an order obtained to self-administer, if appropriate. Personnel authorized to administer medications are responsible for documenting resident's understanding of the use of routine drugs, signs, symptoms and response to use, and based on observation of resident self-administration.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Briar Place Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 West Joliet Indian Head Park, IL 60525	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34072 Based on observations, interviews, and record reviews, the facility failed to determine how a resident sustained bruising to the left side. This affected one of three (R21) residents reviewed for injury of unknown origin. Findings include: On 3/19/24 at 3:15 PM, V57 (Complainant) stated that V57 came to this facility last week and observed a yellow discoloration to R21's left cheek. On 3/20/24 at 3:00 PM, R21 was observed with a yellow discoloration to left cheek. R21 is unable to state how this happened. 3/26/24 at 4:00 PM, R21 was observed to have purple discoloration extending from below left hip to just above knee. R21 is unable to communicate due to aphasia, but is able to answer simple yes/no questions. R21 was able to let surveyor know this discoloration occurred the day before. R21 was unable to provide further details on how this happened. On 3/26/24 at 2:39 PM, V43 CNA (Certified Nurse Aide) stated that he reports any change in the resident's condition to the nurse right away. V43 stated that he does not know how R21 sustained bruising to left cheek. V43 stated that he did not report R21's bruise because it is old. V43 stated that he thought it was reported to V1 (Administrator) because it looked old. When questioned how would he know if R21's left cheek bruising was reported already if he didn't report because it was old, he did not respond. On 3/26/24 at 4:15 PM, V49 CNA was made aware by this surveyor of purple discoloration observed to R21's left lateral thigh extending from below R21's hip and above her knee. V49 stated that V49 was unaware of R21's purple discoloration to left thigh. V49 stated that this discoloration looks old. V49 was unsure how R21 sustained the yellow discoloration to left cheek. V49 stated that R21's skin is fragile. On 3/26/24 at 4:20 PM, V50 (Nurse) stated that V50 was unaware of R21's purple discoloration to left thigh. V50 stated that this discoloration looks old. V50 was unsure how R21 sustained the yellow discoloration to left cheek. On 3/27/24, when questioned if V1 (Administrator) was notified of R21's purple discoloration to her left thigh identified yesterday, V1 responded that the bruise on her thigh was due to a fall and already investigated. V1 stated that R21's family member and R21's insurance provider were concerned about R21's bruising and it was investigated. V1 stated that left thigh discoloration due to fall. When V1 was questioned regarding the yellow discoloration to R21's left cheek, V1 did not respond. R21's medical record notes R21 had a fall on 2/9/24 and sustained bruising to left buttocks and left hip. There is no documentation in R21's medical record regarding left facial bruising. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 12:20 PM, V54 (Attending Physician/Medical Director) stated that a purple discoloration indicates new bruise. V54 stated that the purple discoloration would fade to green yellow discoloration after one to two weeks. V54 denied R21's purple discoloration would be present after one month. R21's abuse care plan, initiated 3/23/22, notes R21 is at risk of abuse due to R21's unclear speech, physical and mental disabilities, residence at nursing facility. This facility's investigation into care related concerns for R21, dated 3/14/24, was reviewed. R21's family noted R21 with skin discoloration while visiting a few days prior. All staff interviews were undated and referred to an incident on 3/14/24. Of these 14 interviews, two staff denied R21 having a recent fall; ten staff denied being aware of any abuse/mistreatment; and two staff noted R21 slipped while in the shower a few weeks prior sustaining bruising to buttocks and thigh. None of the interviews addressed the scratches on R21's arms or the facial bruising. R21's fall incident referenced in this report is noted to have occurred on 2/9/24. The fall incident notes R21 was in the shower and became unsteady and slid to the floor. Bruising noted to left buttocks and thigh. R21's skin alteration review, dated 3/13/24, notes R21 with an abrasion to left elbow, measuring 1.5cm (centimeters) x 6cm. Multiple closed scabs all over left arm also identified. R21 stated that R21 scraped arm on dresser. R21's skin alteration review, dated 3/14/24, notes R21 with redness under right breast. There are no skin alteration review notes, dated 1/1/24 - 3/12/24 and 3/15/24-3/28/24, noting left cheek discoloration or left lateral thigh discoloration. This facility's abuse prevention policy, dated 01/04/2018, notes an injury should be classified as an injury of unknown source if the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. If the cause of an injury of unknown source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and whether the physician, responsible party and/or the Department of Public Health were notified. The procedures and time frames for reporting and investigating abuse will be followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34072 Based on observations, interviews, and record reviews, the facility failed to follow its abuse policy and report an injury of unknown origin to the regulatory agency. This affected one of three residents (R21) reviewed for abuse reporting. Findings include: On 3/19/24 at 3:15 PM, V57 (Complainant) stated that V57 came to this facility last week and observed a yellow discoloration to R21's left cheek. On 3/20/24 at 3:00 PM, R21 was observed with a yellow discoloration to left cheek. R21 is unable to state how this happened. 3/26/24 at 4:00 PM, R21 was observed to have purple discoloration extending from below left hip to just above knee. R21 is unable to communicate due to aphasia, but is able to answer simple yes/no questions. R21 was able to let surveyor know this discoloration occurred the day before. R21 was unable to provide further details on how this happened. On 3/26/24 at 2:39 PM, V43 CNA (Certified Nurse Aide) stated that he reports any change in the resident's condition to the nurse right away. V43 stated that he does not know how R21 sustained bruising to left cheek. V43 stated that he did not report R21's bruise because it is old. V43 stated that he thought it was reported to V1 (Administrator) because it looked old. When questioned how would he know if R21's left cheek bruising was reported already if he didn't report because it was old, he did not respond. On 3/26/24 at 4:15 PM, V49 CNA was made aware by this surveyor of purple discoloration observed to R21's left lateral thigh extending from below R21's hip and above her knee. V49 stated that V49 was unaware of R21's purple discoloration to left thigh. V49 stated that this discoloration looks old. V49 was unsure how R21 sustained the yellow discoloration to left cheek. V49 stated that R21's skin is fragile. On 3/26/24 at 4:20 PM, V50 (Nurse) stated that V50 was unaware of R21's purple discoloration to left thigh. V50 stated that this discoloration looks old. V50 was unsure how R21 sustained the yellow discoloration to left cheek. On 3/27/24, when questioned if V1 (Administrator) was notified of R21's purple discoloration to her left thigh identified yesterday, V1 responded that the bruise on her thigh was due to a fall and already investigated. V1 stated that R21's family member and R21's insurance provider were concerned about R21's bruising and it was investigated. V1 stated that left thigh discoloration due to fall. When V1 was questioned regarding the yellow discoloration to R21's left cheek, V1 did not respond. R21's medical record notes R21 had a fall on 2/9/24 and sustained bruising to left buttocks and left hip. There is no documentation in R21's medical record found regarding R21's left facial bruising. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 12:20 PM, V54 (Attending Physician/Medical Director) stated that a purple discoloration indicates new bruise. V54 stated that the purple discoloration would fade to green yellow discoloration after one to two weeks. V54 denied R21's purple discoloration would be present after one month. This facility has been unable to provide any documentation noting R21's left facial discoloration and left thigh discoloration were reported to the State Surveying Agency on 3/14/24 or 3/26/24. R21's abuse care plan, dated 3/14/24, notes R21 is at risk of abuse due to R21's unclear speech, physical and mental disabilities, residence at nursing facility. On 3/14/24, potential abuse has been investigated, no abuse substantiated. On 3/26/24, potential abuse has been investigated, no abuse substantiated. There is no documentation found in R21's medical record that R21's injuries of unknown origin were reported to the State Surveying Agency. This facility's investigation into care related concerns for R21, dated 3/14/24, was reviewed. R21's family noted R21 with skin discoloration while visiting a few days prior. All staff interviews were undated and referred to an incident on 3/14/24. Of these 14 interviews, two staff denied R21 having a recent fall; ten staff denied being aware of any abuse/mistreatment; and two staff noted R21 slipped while in the shower a few weeks prior sustaining bruising to buttocks and thigh. None of the interviews addressed the scratches on R21's arms or the facial bruising. R21's fall incident referenced in this report is noted to have occurred on 2/9/24. The fall incident notes R21 was in the shower and became unsteady and slid to the floor. Bruising noted to left buttocks and thigh. This facility's abuse prevention policy, dated 01/04/2018, notes an injury should be classified as an injury of unknown source if the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. If the cause of an injury of unknown source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and whether the physician, responsible party and/or the Department of Public Health were notified. The procedures and time frames for reporting and investigating abuse will be followed.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34072 Based on observations, interviews, and record reviews, the facility failed to follow its abuse policy and investigate an injury of unknown origin. This affected one of three residents (R21) reviewed for abuse investigation. Findings include: On 3/19/24 at 3:15 PM, V57 (Complainant) stated that V57 came to this facility last week and observed a yellow discoloration to R21's left cheek. On 3/20/24 at 3:00 PM, R21 was observed with a yellow discoloration to left cheek. R21 is unable to state how this happened. On 3/26/24 at 4:00 PM, R21 was observed to have purple discoloration extending from below left hip to just above knee. R21 is unable to communicate due to aphasia, but is able to answer simple yes/no questions. R21 was able to let surveyor know this discoloration occurred the day before. R21 was unable to provide further details on how this happened. On 3/26/24 at 2:39 PM, V43 CNA (Certified Nurse Aide) stated that he reports any change in the resident's condition to the nurse right away. V43 stated that he does not know how R21 sustained bruising to left cheek. V43 stated that he did not report R21's bruise because it is old. V43 stated that he thought it was reported to V1 (Administrator) because it looked old. When questioned how would he know if R21's left cheek bruising was reported already if he didn't report because it was old, he did not respond. On 3/26/24 at 4:15 PM, V49 CNA was made aware by this surveyor of purple discoloration observed to R21's left lateral thigh extending from below R21's hip and above her knee. V49 stated that V49 was unaware of R21's purple discoloration to left thigh. V49 stated that this discoloration looks old. V49 was unsure how R21 sustained the yellow discoloration to left cheek. V49 stated that R21's skin is fragile. On 3/26/24 at 4:20 PM, V50 (Nurse) stated that V50 was unaware of R21's purple discoloration to left thigh. V50 stated that this discoloration looks old. V50 was unsure how R21 sustained the yellow discoloration to left cheek. On 3/27/24, when questioned if V1 (Administrator) was notified of R21's purple discoloration to her left thigh identified yesterday, V1 responded that the bruise on her thigh was due to a fall and already investigated. V1 stated that R21's family member and R21's insurance provider were concerned about R21's bruising and it was investigated. V1 stated that left thigh discoloration due to fall. When V1 was questioned regarding the yellow discoloration to R21's left cheek, V1 did not respond. R21's medical record notes R21 had a fall on 2/9/24 and sustained bruising to left buttocks and left hip. There is no documentation in R21's medical record found regarding R21's left facial bruising. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 12:20 PM, V54 (Attending Physician/Medical Director) stated that a purple discoloration indicates new bruise. V54 stated that the purple discoloration would fade to green yellow discoloration after one to two weeks. V54 denied R21's purple discoloration would be present after one month. This facility has been unable to provide any documentation noting R21's left facial discoloration and left thigh discoloration were investigated R21's abuse care plan, initiated 3/14/24, notes R21 is at risk of abuse due to R21's unclear speech, physical and mental disabilities, residence at nursing facility. On 3/14/24, potential abuse has been investigated, no abuse substantiated. On 3/26/24, potential abuse has been investigated, no abuse substantiated. There is no documentation found in R21's medical record that R21's injuries of unknown origin were investigated. This facility's investigation into care related concerns for R21, dated 3/14/24, was reviewed. R21's family noted R21 with skin discoloration while visiting a few days prior. All staff interviews were undated and referred to an incident on 3/14/24. Of these 14 interviews, two staff denied R21 having a recent fall; ten staff denied being aware of any abuse/mistreatment; and two staff noted R21 slipped while in the shower a few weeks prior sustaining bruising to buttocks and thigh. None of the interviews addressed the scratches on R21's arms or the facial bruising. R21's fall incident referenced in this report is noted to have occurred on 2/9/24. The fall incident notes R21 was in the shower and became unsteady and slid to the floor. Bruising noted to left buttocks and thigh. R21's skin alteration review, dated 3/13/24, notes R21 with an abrasion to left elbow, measuring 1.5cm (centimeters) x 6cm. Multiple closed scabs all over left arm also identified. R21 stated that R21 scraped arm on dresser. R21's skin alteration review, dated 3/14/24, notes R21 with redness under right breast. There are no skin alteration review notes, dated 1/1/24 - 3/12/24 and 3/15/24-3/28/24, noting left cheek discoloration or left lateral thigh discoloration. This facility's abuse prevention policy, dated 01/04/2018, notes an injury should be classified as an injury of unknown source if the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. If the cause of an injury of unknown source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and whether the physician, responsible party and/or the Department of Public Health were notified. The procedures and time frames for reporting and investigating abuse will be followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 34072 Based on interviews and record reviews, the facility failed to follow its wound policy and showering protocol and provide residents with a shower and perform a skin assessment once a week. This failure affected 7 residents (R7, R10, R15-R19) out of 7 residents reviewed for showers and skin assessments. Findings include: On 3/26/24 at 9:05 AM, R35 was observed at the nurses' station asking to take a shower. V31 CNA (Certified Nurse Aide) was observed unlocking the shower room door for R35. On 3/26/24, continuous observation of shower room was done from 9:05 AM - 9:20 AM. No staff were observed entering into the shower room to monitor R35 or perform a skin assessment. On 3/26/24 at 9:20 AM, R35 exited shower room fully clothed, disposed of used towels in linen bin and went to his room. On 3/20/24 at 1:55pm, V2 DON (Director of Nursing) stated that the nurse performs skin assessments weekly on residents's shower days. V2 stated that there is a shower binder containing the shower schedule on each nursing unit. V2 stated that showers are performed weekly. V2 stated that the baseline is weekly, but residents can shower more often if they request. On 3/21/24 at 11:30 AM, V26 (Nurse) stated that if a resident refuses showers, the CNA would notify of V26 of refusal. V26 stated that V26 would speak with R17 if R17 refused a shower and V26 could get R17 to agree to take a shower. V26 stated that staff should be in shower room monitoring the resident during shower. V26 stated that skin assessments are performed on shower days by CNA; CNA would inform V26 if there was any skin issue identified. V26 stated that he would also perform a skin assessment to verify shower sheet documentation is accurate before signing it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/24 at 2:00 PM, V2 reviewed all of the shower sheets for August and September 2023 that were presented. V2 stated that the nurse completes the top portion of the shower sheet and the CNA completes the bottom section. V2 stated that the back of shower sheet is completed by nurse and CNA if a resident refuses shower or receives bed bath. V2 stated that the skin assessment should be marked either skin intact or identifying any skin issues. V2 stated that the nurse is expected to perform skin assessment on shower days. V2 stated that the CNA is expected to mark the picture of a figure with any skin issues identified. V2 stated that the CNAs complete the shower sheet, but it should be part of their ADLs (activities of daily living) documentation. V2 stated that V2 is unable to locate shower sheet/skin assessments for R7, R16, R17, or R18 for August 2023 or September 2023. V2 was unable to locate shower sheets/skin assessments for R10, R15, or R19 for September 2023. V2 acknowledged that R10 received one shower in August on 8/3/23 and that the nurse noted skin assessments were performed on 8/3, 8/7, 8/10, and 8/21 but did not identify if R10's skin was intact or if any skin issues were present. V2 stated that R10's skin assessments are incomplete. V2 acknowledged that R15 received a shower on 8/3/23, 8/12/23, and 8/26/23, the nurse did not perform any skin assessments to identify if skin intact or skin issues present. V2 acknowledged that R21 received a shower on 8/3/23, 8/9/23, and 8/15/23, the nurse did not perform any skin assessments to identify if skin intact or skin issues present. On 3/21/24 at 2:40 PM, V28 CNA stated that she is familiar with R17. V28 stated that R17 was compliant with taking showers. V28 stated that she documents on shower sheet and identifies any skin issues and notifies nurse. On 3/21/24 at 3:30pm, V33 RN stated that skin assessments are done on the resident's shower day. V33 stated that she performs assessment herself to verify skin intact or if there are any new skin issues. Shower sheets for August and September 2023 were reviewed. There were no shower sheets found noting R7, R16, R17, and R18 received any showers/skin assessments in August 2023. There were no shower sheets found noting R7, R10, R15, R16, R17, R18, and R19 received any showers/skin assessments in September 2023. R10 received a shower on 8/3/23, no skin assessment completed by the nurse. R15 received a shower on 8/3/23, 8/12/23, and 8/26/23, but there is no documentation noting the nurse performed any skin assessments on those days. R19 received a shower and skin assessment on 8/1, 8/8, 8/14, 8/23, 8/30. This facility's wound policy, revised 07/2022, notes residents should be examined thoroughly at least weekly by a licensed nurse. Findings from the weekly skin assessment should be documented/signed off by the licensed nurse. Nurse aides should complete a shower sheet on all residents when they are bathed or showered and given to the nurse. Any skin impairments should be assessed and documented weekly.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 Based on interviews and record reviews, the facility failed to follow its presumed death policy and initiated CPR (cardiopulmonary resuscitation) on a resident exhibiting obvious signs of irreversible death including: R17 with the presence of rigor mortis in jaw, lividity (blood pooling) in back and legs, and absence of vital signs, and R28 with full rigor mortis throughout the body and asystole. This failure affected two residents (R17 and R28) out of four residents reviewed for acute change in condition in a sample of 35. On [DATE], R17 expired in this facility at 11:36 PM due to cardiac/respiratory arrest. On [DATE] R28 expired in this facility at 6:11AM with cause of death as combined drug toxicity: Drug fentanyl Acetyl despropionyl fentanyl. Findings include: 1. On [DATE] at 10:41 PM, V53 RN (Registered Nurse) stated that V53 started her shift on [DATE] at 11:00 PM and made rounds on the residents. V53 stated that during rounds she observed R17 not responsive and without pulse and respirations. V53 stated that she called a code blue and other staff responded to R17's room. V53 stated that she brought the emergency cart to R17's room and was assembling equipment when EMS (emergency medical services) arrived. V53 stated that she does not recall which staff responded to the code blue. V53 stated that she does not recall if she provided chest compressions or assisted ventilations with the bag-valve-mask. V53 stated that the EMS crew arrived at R17's bedside and took over care of R17. V53 stated that EMS crew were not at facility for long and left without taking R17. R17's progress notes, dated [DATE] at 11:15 PM, V53 RN noted R17 lying in supine position on his bed, pale, not breathing, no carotid or radial pulse, skin warm to touch. Checked status. Code blue was announced. Co-nurse called EMS 911. CPR initiated. At 11:30 PM, V53 noted EMS paramedics worked on R17 then was seen outside R17's room standing around stretcher talking to each other then informed staff that they will not be taking R17. On [DATE] at 12:50 PM, V52 LPN (Licensed Practical Nurse) stated that she is unsure what time she actually left the faciity on [DATE]. V52 informed that the staffing sheet for [DATE] notes she was working until 8:00 PM. V52 stated that on that day she may have only worked until 8:00 PM. V52 stated that R17 was usual self throughout her shift. V52 stated that she parks her medication cart outside of R17's door and residents approach her for their medications. V52 stated that R17 came to her cart and received his medications. V52 stated that the last time she saw R17 was when he received his medications. R17's progress notes, dated [DATE], V52 LPN noted R17 alert and verbally responsive, due medications given and tolerated well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Briar Place Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 West Joliet Indian Head Park, IL 60525	

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:54 AM, V51 (EMS Paramedic) stated that EMS responded to a call at this facility. V51 stated that upon entering R17's room, he observed R17 exhibiting rigor mortis as evidenced by R17's jaw clenched shut. R17 was also exhibiting lividity of back and legs when paramedics rolled R17 on his side to assess R17's back. V51 stated that when a person has rigor in the jaw, he/she has been deceased for ,d+[DATE] hours already. V51 stated that the EKG (electrocardiogram) leads were applied to R17's chest and showed asystole (no movement within the heart). V51 stated that there is no coming back from asystole when there is rigor present. V51 stated that upon exiting R17's room, EMS observed staff speaking with a police officer. On [DATE] at 6:55 AM, V56 CNA (Certified Nurse Aide) stated that she worked night shift on [DATE]. V56 stated that a code blue was called and all available nurses in facility responded. V56 stated that her co-worker administered ventilations via bag valve mask and she performed chest compressions. V56 stated her co-worker stayed over to help them out because they were short staffed on night shift. On [DATE] at 7:00 AM, V62 LPN (Licensed Practical Nurse) stated that she was not assigned to provide care for R17 on [DATE]. V62 stated that V53 RN was rounding on her assigned residents when V53 found R17 unresponsive. V62 stated that she does not recall if she called EMS 911 or her role in providing CPR to R17. V62 stated that she printed R17's paperwork for hospital and EMS. R17's death certificate notes primary cause of death was cardiorespiratory failure. R17's EMS report, dated [DATE], notes EMS was called at 11:23 PM for a resident in cardiac arrest/death. EMS was at R17's bedside at 11:32 PM. R17 was found by facility staff unconscious and unresponsive. Staff could not confirm when the last time R17 was seen by staff. R17 found by oncoming staff unconscious and unresponsive. CPR initiated. Exam found rigor in the jaw and lower extremities. R17's body cold with lividity to back and legs. 4-lead electrocardiogram showed asystole (no movement in the heart). Medical control at hospital notified and arrest called at 11:36 PM. Scene and R17 turned over to police officer. R17's police report, dated [DATE], notes Police and Fire units arrived at approximately same time. CPR in progress by staff. Upon contact with R17, paramedics advised R17 was not workable, with rigor mortis being present in jaw area with jaw locked and postmortem lividity present in fingertips and back area, with onset of death estimate of +3 hours prior. V53 RN was doing checks and located R17 unresponsive at 11:15PM at which 911 was contacted and CPR begun. V53 further related that prior check was approximately 5:00 PM by V52 LPN. 41156 2. R28 was admitted in the facility on [DATE] and expired on [DATE]. R28 is a [AGE] year old female resident. R28 has diagnoses but not limited to: post-traumatic stress disorder, psychoactive substance abuse, anxiety disorder, major depressive disorder, attention-deficit hyperactivity disorder and suicidal ideation. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurses Notes dated [DATE] 05:45, reads in part: Upon rounds at this time, observed R28 in bed lying on Left side. Called her name, not easily aroused. Unresponsive verbally and tactile. Upon further assessment she appeared not to be breathing. Code blue immediately called, CPR Initiated. All staff Nurses responded. 911 Emergency was called and they arrived immediately. CPR (Cardio Pulmonary Resuscitation) continuous EMS (Emergency Medical Services) resumed CPR. Police present. Patient's mother already notified and in the facility as well as the Director of Nursing. EMS Continued CPR then called the Time of Death 6:18A.M. On [DATE] at 11:30AM, V39 (CNA) reported that 11pm was the beginning of V39 shift and R28 was in bed awake watching television. Around 12AM sleeping, in bed. Verified how he knows that resident was just sleeping and V39 stated R28's chest was rising and falling. Around 1AM R28 was observed coming out from the bathroom, walking, heading back to her bed. Around 2AM he saw R28 awake lying in bed, called R28 name and R28 answered by grunting. Sounded like R28 was just about to fall asleep. Around 3AM to 3:30AM stated that V39 saw R28 in bed, with her eyes open and noticed the chest is not moving. Touched R28 on her shoulder and tried to wake her up and did not answer. V39 stated R28 still slightly warm to touch when he touched R28 on her shoulder. V39 called the nurse, nurse called code blue and they started CPR. When asked how V39 can be sure that it was around the time of 3am to 3:30 and replied, it just feels like it was around that time. On [DATE] at 12:00PM, V38 (NURSE) stated that beginning of her shift V38 received report from outgoing nurse and V38 did her rounds. R28's door was closed. Knocked on R28's room and R28 responded one minute, came in and saw R28 coming out of the washroom, walking. Asked R28 if R28 needs anything and R28 said I'm okay and good night stated V38 does V38's rounding every hour or so. Around 1:45AM, R28 in bed, laying on her back, asleep with even and unlabored breathing. Around 3:45AM, still asleep in bed, unlabored breathing. Around 5:30AM, V38 was passing meds, she went to R28's room to see if anyone in the room is awake and ready for their medication. R28 was in bed, with the night light on, asleep, looking peaceful, noticed chest was not rising, and no pulse. Tried to do chest rub for response and R28 did not response. V38 cannot recall R28 color at the time but recalls R28 still slightly warm to touch. R28 eyes were closed. Called 911, 911 arrived right away. Denied that CNA called her and informed her that R28 was unresponsive in bed. V38 stated she was the one that found R28 unresponsive in bed. Fire Department Runsheet dated [DATE], reads in part: Unit notified [DATE] at 5:56AM, Unit arrived at scene at 6:03AM, and patient contact at 6:04AM. Called for Cardiac Arrest. Found nursing home staff attempting CPR on [AGE] year old resident. Unknown PMH. Unknown last time patient was seen normal. Unknown what time patient was found not breathing. Exam, patient cyanotic from the neck up. Patient with full rigor throughout body. 4 lead applied confirmed asystole. ER call for medical control. Medical control confirmed DOA (Dead on Arrival) at 6:11AM. On [DATE] at 9:30AM, V63 (Fire Chief) When it is document such Unknown last time patient was seen normal. Unknown what time patient was found not breathing, meaning none of the facility staff were able to report to EMS the last time they saw the resident breathing and normal. Full rigor throughout the body become visible at least 2 hours after death. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Presumed Death Policy (no date), reads in part: In the absence of a Do Not Resuscitate order, Resuscitation will not be performed if the resident is presumed and confirmed dead by two license nurses (whether LPN and/or RN). Two nurses (LPN and or RN) must determine the presence of the following: pupils fixed and dilated as indicated by shining a bright light in both eyes. No spontaneous respiration. Molted discoloration of the body. No spontaneous movement and absence of vital signs (apical pulse and blood pressure). The A through E findings shall be documented in the nursing notes along with the name of both nurses (LPN and/or RN).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34072 Based on observations, interviews, and record reviews, the facility failed to ensure medication is taken when administered and accounted for. This affected one of three (R15) residents reviewed for medication. This failure resulted in medication being left at R15's bedside, and loose medication being found on the floor unaccouted for. Findings include: On 3/20/24 at 8:10 AM, a white oval tablet was observed in-between two medicine cups with resident's last name on each cup. R15 stated that she was unaware that medication was on her bedside table. On 3/20/24 at 8:15 AM, this white tablet was identified by V44 (Nurse) as Topirimate. V44 stated that Topiramate is given to R15 to prevent seizures. V44 stated that R15 receives this medication twice daily. V44 unaware when this medication was placed on R15's bedside table. On 3/21/24 at 2:00 PM, V2 DON (Director of Nursing) said that the nurse is expected to stay with resident to make sure resident takes medication and to make sure the resident does not have an adverse reaction to the medication. On 3/26/24 at 8:15 AM, this surveyor observed two pills on the floor in front of the nurses' station. On 3/26/24 at 9:00 AM, V2 DON came to the nursing unit to identify medications found on the floor. V2 stated that the white oval tablet is atorvastatin (treat high cholesterol) and the peach half tablet is taltz (medication to treat plaque psoriasis (skin condition)). V2 stated that the nurse should monitor residents while administering medications to ensure all medications are taken as prescribed. V2 stated that the nurses should check to ensure there are no medications on the floor so other residents cannot take medications not prescribed to them. On 3/28/24 at 12:20 PM, V54 (medical director) stated that medications should not be left at a resident's bedside especially if the resident has a diagnosis of dementia. V54 stated that it is a nursing standard of practice to remain with the resident while administering medications. V54 was informed that two medications were observed on the floor in front of the nurses' station, V54 responded that the nurses should be checking the area where the residents are taking medication to ensure that no medications are dropped. R15's medical record notes R15 with diagnosis of dementia. R15's POS (physician order sheet), dated 5/8/23, notes an order for topiramate 25mg (milligrams) tablets, give three tablets by mouth two times a day for anticonvulsant, three tablets for total of 75mg. R15's MAR (medication administration record), dated March 2024, notes topiramate is scheduled to be administered at 6:00 AM and 9:00 PM daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This facility's administering medications policy, dated 1/1/2020, notes medications may only be administered to the individual in which the medication was prescribed. Medications shall be administered in physician's written orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity. Medications should be administered within one hour of the prescribed times.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41156 Based on interview and record review, the facility failed to effectively supervise a resident with history of drug abuse. This deficient practice affects one resident of three residents reviewed for change in condition. R28 had multiple incidents of noncompliance for bringing in contraband and R28 tested positive for cocaine once during R28's stay in the facility. R28 expired on [DATE] in the facility with cause of death as combined drug toxicity: Drug fentanyl Acetyl despropionyl fentanyl raised to the level of an Immediate Jeopardy. The Immediate Jeopardy began on [DATE] when R28 was found to be unresponsive at the bedside without breath. V1 (Administrator) and V2 (Director of Nursing) were notified of the Immediate Jeopardy on [DATE] at 10:18am. The surveyor confirmed by onsite observation, interview and record review that the immediacy was removed on [DATE], but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings Include: R28 was admitted in the facility on [DATE] and expired on [DATE]. R28 is a [AGE] year old female resident. R28 has diagnoses but not limited to: post traumatic stress disorder, psychoactive substance abuse, anxiety disorder, major depressive disorder, attention-deficit hyperactivity disorder and suicidal ideation. R28's notes for Initial Meeting for [NAME]/Alcohol and Substance Abuse program/Introduction dated [DATE], reads in part: R28 noted using heroin and cocaine. R28 also reported that she was prescribed Vicodin (controlled substance pain medication) after car accident which caused R28 to start using again. R28 further reported using heroin for 5 or 6 years. Per medical records, R28 was noncompliant with her psychotropic medications. R28 was told that R28 will be referred to the [NAME] program for poly0substance abuse. R28 was made aware that this facility has zero tolerance for using alcohol, THC (Tetrahydrocannabinol-found in cannabis) or any mood-altering substances while in treatment inside and outside the facility and random UDS (Urine Drug Screening) and BAC (Blood Alcohol Concentration) will be administered and for suspicion of using. Social Service Note dated [DATE], reads in part: writer met with R28 due to R28 being on 72-hour smoking restriction as there was contraband found in her room. Writer re-educated R28 on the smoking policy and encouraged R28 to refrain from bringing contraband into the facility. Social Service Note dated [DATE], reads in part: Staff reported that R28 was seen with contraband in R28's room on [DATE]. Writer approached R28 about the situation. R28 was calm when talking to the writer. Writer reminded R28 about the house rules. After releasing R28's frustration, R28 began to understand what writer explained to R28. Care plan will be updated as needed. Staff will continue to monitor accordingly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Social Service Note dated [DATE], reads in part: Writer spoke to R28 after witnessing R28 smoking in the hallway. Writer confiscated R28's vape and re-directed R28 to social service office. R28 stated to have gotten them when R28 went out and forgot to turn it over. Writer educated R28 on the house rules regarding smoking materials outside of designated area and encouraged R28 to turn in material at the front desk upon re-entry. Due to multiple violations, R28 smoking privileges will be taken for 30 days. Social Service Note dated [DATE] reads in part: Writer notified that on [DATE] R28 had contraband. Upon entering the room bathroom was not smoky as R28 exiting the bathroom. An unlit cigarette was located in R28's bedroom. R28 was educated about the hazards/safety risks of smoking inside the facility. R28 is restricted from smoking for 30 days. Social Service Note dated [DATE] at 12:30PM, reads in part: Conducted a random UDS (Urine Drug Screening) and results were positive for THC and opioids. It is apparent that R28 currently uses THC and R28 takes pain pill under doctor's and facility's supervision. R28 stated I smoked a joint at the reunion but did not do other drug or alcohol. CADC (Certified Alcohol and Drug Counselor) commended R28 not using other mood-altering substances. Furthermore, CADC told R28 that R28 cannot use marijuana while in treatment. Offered another level of treatment but R28 refused, stating it's only marijuana. Will continue [NAME] (mental illness and substance abuse) programming. Social Service Note dated [DATE] at 12:36PM, reads in part: Writer met with R28 due to having contraband. Upon entering room, bathroom was not smoky as R28 was exiting the bathroom. A vape was located in R28's bedroom. R28 is restricted from smoking for 60 days. Social Service Note dated [DATE], reads in part: R28 mother called and spoke to writer, when she was out of town, R28 was caught using cocaine with first cousin and lying about her drug use. Will follow up. Social Service Note dated [DATE], reads in part: CADC and R28's mom met briefly yesterday impromptu as she was coming to visit R28. R28's current drug use activity and last positive UDS (THC and Cocaine) were discussed in the meeting. Both agreed that inpatient or residential treatment for R28 is recommended, will continue to follow up. Contract for Refusing Inpatient Residential Treatment dated [DATE], reads in part: R28 has been observed on several occasions with positive UDS with THC and opiates which she is currently taking while under supervision of doctors and other IDT members. The latest UDS was positive for cocaine. Her Drug and Alcohol Therapist has offered R28 an opportunity to attend an inpatient or residential Treatment for her substance abuse issues but R28 adamantly refused to do so. On [DATE] at 11:15AM, V17 (Substance Abuse Coordinator) stated in regards to [DATE] contract positive result of cocaine: It was false positive, I should have documented false positive and not positive for cocaine. We asked R28 and R28 denied it, and there could be over the counter medication that can give false positive result. Based on my clinical observation and assessment that day, the result was false positive, but I did not document because I did not see it would be important to document my clinical observation and assessment at the time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Social Service Note dated [DATE], reads in part: Writer was informed that resident was caught in possession of contraband. Social service staff confiscated the items (Vape and THC pens) and performed consensual room search. R28 placed on 90-day smoking restriction. On [DATE] at 1PM, V4 (Social Service Director) regarding delivered items, reception will check and if the social services are available they will also check. Unfortunately we are not able to do search for visitors. We check the package once the package is left by the visitor to any residents. Regarding [DATE] we confiscated contraband, vape /THC pen was found. We checked and searched the whole room and nothing else was found. R28 was placed on smoking restriction. V4 cannot recall how R28 got the vape. R28 was already on red pass. R28 can go out to community with family members and friends but not unsupervised. Someone has to sign R28 out before R28 can go out on pass. On [DATE] at 1:15PM, V4 stated that for dropped off essential items and groceries, social service brings it to the residents. Reception will call the nurse to come and get the food delivered and the receptionist should have checked it prior to calling and giving it to the nurse. Unless the resident is waiting down in the unit by the reception area, the receptionist will check the bag before giving it to the resident. Also, front desk will inform the social service that a family member/ other visitors coming in with bag of items. If dropping it off, then social service will come down and search and if visitor is staying and coming in with bag of items then the reception will check the bag. On [DATE] at 10AM, V24 (Receptionist) stated that V4 will notify the nurse that a family member will bring a bag of snacks for the nurse to check in the nurses station. Because I do not know the residents diet. I will call the nurse and let them know that a family member is on their way with a bag of snacks. Outside deliveries, they come in they show us their phone and show us they are here to deliver something. Sometimes residents will come down and wait for the delivery person and wait for them on the other side of the door (receptionist area to facility floor unit). In regards to groceries, Social service will check. I will inform social service that a grocery is delivered or dropped off. Social service need to be present when handing the bag to the resident. Food delivery service, it has to be given unopened to the resident. We don't check if with the receipt and the bag is closed. On [DATE] at 3:30 PM, V17 (Substance Abuse Coordinator), stated that due to history of drug use while in the facility, R28 was counseled not to do drugs anymore. In general, a resident that tested positive for illegal drugs we will try to find out where they got the drugs from. We notify the MD. If they have a guardian we will notify the guardian. High level treatment which is inpatient was offered to R28. R28 refused. Our intervention was to continue with the current intervention in the care plan. No new specific intervention added at the time she tested positive for cocaine. Staff to encourage R28 to attend group meeting such as AA meeting. Increase one to one meeting. Nurses Notes dated [DATE] 05:45, reads in part: Upon rounds at this time, observed R28 in bed lying on Left side. Called her name, not easily aroused. Unresponsive verbally and tactile. Upon further assessment she appeared not to be breathing. Code blue immediately called, CPR Initiated. All staff Nurses responded. 911 Emergency was called and they arrived immediately. CPR (Cardio Pulmonary Resuscitation) continuous EMS (Emergency Medical Services) resumed CPR. Police present. Patient's mother already notified and in the facility as well as the Director of Nursing. EMS Continued CPR then called the Time of Death 6:18AM. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Fire Department Runsheet dated [DATE], reads in part: Unit notified [DATE] at 5:56AM, Unit arrived at scene at 6:03AM, and patient contact at 6:04AM. Called for Cardiac Arrest. Found nursing home staff attempting CPR on [AGE] year old resident. Unknown PMH. Unknown last time patient was seen normal. Unknown what time patient was found not breathing. Exam, patient cyanotic from the neck up. Patient with full rigor throughout body. 4 lead applied confirmed asystole. Local ER call for medical control. Medical control confirmed DOA (Dead on Arrival) at 6:11AM.

On [DATE] at 10AM, V60 (R28's complainant) Reported that after R28's death, they checked R28's text messages on her cellphone and R28 was in communication with somewhat an Uber driver stating that the drugs will be placed inside the hair coloring box. Was not specific what kind of drugs it was and was not able to give the date of this transaction conversation through text messages. V60 reported that R28 died of drug overdose.

On [DATE] at 11:25AM, V61 (Coroner's office personnel) confirmed cause of death for R28 as written in R28's Death Certificate as combined drug toxicity: Drug fentanyl Acetyl despropionyl fentanyl.

Physician Order sheet reviewed and there is no order for Fentanyl medication.

Resident Handbook revision date [DATE], reads in part: Room, Personal and Body Searches. Staff members perform room checks every day. Staff will check each resident room to ensure a clean and safe environment. You may be present at the times of these room checks. Please be aware that staff will be checking all closets, dressers, suitcases and shelving. Certain items are not permitted in your room for your safety and safety of others. Some items not allowed in the facility, include but not limited to: Firecrackers or any kind of chemicals or flammable materials. Any poisonous materials.

Guidelines for Community Access Determination dated [DATE], reads in part: Resident personal belongings will be searched upon entry and re-entry to the facility.

[DATE] Alcohol/Substance Use/Abuse policy reads in part:

Substance Use/Abuse Policy objective

It is the policy of the nursing facility to provide a safe and healthy living environment. The facility recognizes that persons requiring long-term care present with significant physical and mental health problems. In some situations, the person may have a history of substance abuse. The facility recognizes that substance use/abuse disorders result in substantial physical and mental impairment disability and recognize the personal responsibility of the individual to seek and remain engaged in treatment. The facility shall work with the individual to provide appropriate treatment referrals to enable the individual to work on abstinence, sobriety, personal improvement and reducing chances of recidivism.

Appropriate interventions are strongly recommended to persons with substance abuse problems.

Each resident (and/or representative) is informed that facility policy prohibits the use of alcohol without a doctor's order. Facility policy prohibits use of illicit drugs. As a condition of residence, each person living in the facility acknowledges that he/she will not use alcohol or illicit drugs during residence in this building.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145784	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Briar Place Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 West Joliet Indian Head Park, IL 60525	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Persons returning from the community who present with signs and symptoms of intoxication will be evaluated by the nurse on duty or charge nurse. The nurse is responsible for taking vital signs and assessing the person's present behavior. The nurse will be responsible for contacting the attending physician (A.P.) if the resident is determined to be in need of medical attention and/or a decision is required regarding withholding prescribed medications. Documentation will be placed in the chart regarding signs/symptoms of intoxication/inebriation. Documentation should include the resident's own admission of alcohol/drug use. The facility reserves the right to have the person submit to blood/urine testing at any time if policy violation is suspected. Follow-up interventions and treatment recommendations will be communicated to the resident/representative and documented in the medical record. Outside treatment sources will be utilized as appropriate. Residents with substance abuse disorders are expected to participate in acute/active treatment, sobriety counseling, or aftercare Persons who continually jeopardize their health and the health and safety of others will be evaluated for involuntary discharge. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy. 1. A system to ensure contraband does not enter the facility and is removed from the resident will be achieved through staff education. Education will be provided by the Administrator, to registered nurses, licensed practical nurses, CNAs, social workers, activity staff, security guards, housekeeping staff, dietary staff, maintenance staff, reception staff, human resources director, and the business office manager. This education will review the facility's contraband policy updated on [DATE] and will include that residents may be asked to voluntarily empty and show the contents of their pockets at any time if reasonable suspicion exists. Reasonable suspicion includes frequent leaves of absence with or without facility knowledge, odors, new needle marks, and changes in resident behavior such as unexplained drowsiness, slurred speech, lack of coordination, mood (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	changes, particularly after interaction with visitors or absences from the facility. Residents may be asked to voluntarily reach into concealed clothing areas and remove any items and place these items on a horizontal surface. Staff are instructed to have the resident hand items to the staff members or place the items on the horizontal surface. It is the objective of this policy that the above steps occur in plain sight of multiple witnesses (if possible) to afford appropriate protection to both the resident and the involved staff member(s). These steps are necessary to assure that the resident is treated with respect and dignity throughout the procedure. It is appropriate to ask the resident to empty his/her pockets and display their contents or roll down his/her socks. It is not appropriate to bring a resident into a room for a more specific search unless there is strong suspicion that the individual is attempting to bring in objects/items that may cause serious harm. If a more specific search is required the staff are to follow guidelines as set forth by the administrator or the administrative representative. This may even involve requesting professional assistance from the local police. Only outerwear articles of clothing including, but not limited to, jackets, coats, scarves, hats, gloves, and vests, shall be removed in plain site of staff. This policy recognizes that residents have attempted to hide/conceal contraband articles in undergarments in the past. If this appears to be the case and staff assess and suspect that these items may cause harm, staff are directed to contact the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administrator or the administrative representative for instructions on how to proceed. The facility emphasizes treatment with dignity at all times. The facility reserves the right to remove locks from drawers, cabinets, closets, lockers, or any other object if there is reason to suspect that the resident possesses any item or items that may potentially harm other persons. The facility may choose, at its discretion, to involve drug-sniffing dogs (e.g., from a K9 company) if residents are suspected to be trafficking drugs inside the facility. A root cause analysis will be completed upon identification of contraband. This education began on [DATE] and will be completed by [DATE]. Upon completion of the training, staff will sign an will contact agency staff before their scheduled shift to review staff education regarding the prevention of contraband from entering the facility and the removal of contraband from resident possession. A binder with staff education will be kept at the front desk and agency staff will be required to read and sign to validate their understanding of the information presented in the binder. If agency nurses have any questions regarding the information presented in the staff education binder, they will be instructed to contact the Director of Nursing for clarification prior to signing the record of education. In the absence of the Director of Nursing, the Assistant Director of Nursing will review the education requirements and answer any questions for agency nurses. The facility has identified five staff members who are on a leave of absence/vacation. These (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff members will be contacted by the Administrator to review staff education regarding the prevention of contraband from entering the facility and the removal of contraband from resident possession. The staff education will be placed in a binder at the front desk and must be reviewed and signed by the staff member before returning to work. The staff member will sign a record of education to validate their understanding of the information presented in the binder. If the staff have any questions regarding the education, they will be instructed to contact the Administrator before signing the record of education. In the Administrator's absence, the Director of Nursing will answer questions regarding the education. Additionally, this education will be provided to new staff upon hire during orientation training and will be repeated to all staff including registered nurses, licensed practical nurses, CNAs, social workers, activity staff, security guards, housekeeping staff, dietary staff, maintenance staff, reception staff, human resources director, and the business office manager annually. Record of continuing education sheet to confirm their knowledge and understanding of the topic presented. The Director of Nursing will contact agency staff before their scheduled shift to review staff education regarding the prevention of contraband from entering the facility and the removal of contraband from resident possession. A binder with staff education will be kept at the front desk and agency staff will be required to read and sign to validate their (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	understanding of the information presented in the binder. If agency nurses have any questions regarding the information presented in the staff education biner, they will be instructed to contact the Director of Nursing for clarification prior to signing the record of education. In the absence of the Director of Nursing, the Assistant Director of Nursing will review the education requirements and answer any questions for agency nurses. The facility has identified five staff members who are on a leave of absence/vacation. These staff members will be contacted by the Administrator to review staff education regarding the prevention of contraband from entering the facility and the removal of contraband from resident possession. The staff education will be placed in a binder at the front desk and must be reviewed and signed by the staff member before returning to work. The staff member will sign a record of education to validate their understanding of the information presented in the binder. If the staff have any questions regarding the education, they will be instructed to contact the Administrator before signing the record of education. In the Administrator's absence, the Director of Nursing will answer questions regarding the education. Additionally, this education will be provided to new staff upon hire during orientation training and will be repeated to all staff including registered nurses, licensed practical nurses, CNAs, social workers, activity staff, security guards, housekeeping staff, dietary staff, maintenance staff, reception staff, human resources director, and the business office (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	manager annually. 2. A system to prevent residents with a history of substance abuse from introducing contraband into the facility or obtaining contraband in the facility will be achieved through staff education. Education will be provided by the Administrator to registered nurses, licensed practical nurses, CNAs, social workers, activity staff, security guards, housekeeping staff, dietary staff, maintenance staff, reception staff, human resources director, and the business office manager. This education will review the facility's policy on Alcohol/Substance Use/Abuse updated on [DATE]. The education will review that Each resident (and/or representative) is informed that facility policy prohibits the use of alcohol without a doctor's order. Facility policy prohibits the use of illicit drugs. As a condition of residence, each person living in the facility acknowledges that he/she will not use alcohol or illicit drugs during residence in this building. Persons assessed with an active substance abuse problem are offered appropriate treatment and rehabilitative services. While this policy addresses illicit drugs and alcohol, the same standards and expectations are in place for persons with a prescription narcotic addiction. These individuals are also responsible for engaging in appropriate treatment to reduce/eliminate dependency on opioids. Persons returning from the community who present with signs and symptoms of intoxication will be evaluated by the nurse on duty or charge nurse. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The nurse is responsible for assessing the person's physical condition and present behavior. The nurse will be responsible for contacting the attending physician (A.P.) if the resident is determined to be in need of medical attention and/or a decision is required regarding withholding prescribed medications. Documentation will be placed in the chart emphasizing signs/symptoms of intoxication/inebriation (such as smell of alcohol, behavior changes, balance/gait problems, appearance of the eyes, and change in speech pattern). Documentation should include the resident's own admission of alcohol/drug use. The facility reserves the right to have the person submit to blood/urine testing at any time if policy violation is suspected. Persons who are evaluated as medically unstable will be transferred for appropriate medical care. Follow-up interventions and treatment recommendations will be communicated to the resident/representative and documented in the medical record. Outside treatment sources will be utilized as appropriate. Residents with substance abuse disorders are expected to participate in acute/active treatment, sobriety counseling, or aftercare interventions, as appropriate to their personal situation. The facility has the right to implement money management interventions pursuant to federal law if substance abuse continues. Persons who continually jeopardize their health and the health and safety of others will be evaluated for involuntary discharge. Education will include instruction on how to identify which residents (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	have a substance abuse disorder and how to locate resident-specific interventions to prevent them from obtaining contraband while in the facility. This information will be kept in binders at the nurse's stations. The binders will include a list of residents with substance abuse disorders and information on resident-centered interventions to prevent them from obtaining contraband while in the facility. These binders will be updated by social services weekly and with resident changes in condition. This education began on [DATE] and will be completed [DATE]. Upon completion of this education, staff will sign a record of continuing education to confirm their knowledge and understanding of the information presented. This education will be provided to new staff upon hire during orientation training and will be repeated to all staff including registered nurses, licensed practical nurses, CNAs, social workers, activity staff, security guards, housekeeping staff, dietary staff, maintenance staff, reception staff, human resources director, and the business office manager annually. The Director of Nursing will contact agency staff before their scheduled shift to review staff education regarding the prevention of residents with substance abuse disorders from introducing contraband into the facility or obtaining contraband in the facility. A binder with staff education will be kept at the front desk and agency staff will be required to read and sign to validate their understanding of the information presented in the binder. If agency nurses have any questions regarding the information (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	presented in the staff education biner, they will be instructed to contact the Director of Nursing for clarification prior to signing the record of education. In the absence of the Director of Nursing, the Assistant Director of Nursing will review the education requirements and answer any questions for agency nurses. The facility has identified five staff members who are on a leave of absence/vacation. These staff members will be contacted by the Administrator to review staff education regarding the prevention of residents with substance abuse disorders from introducing contraband into the facility or obtaining contraband in the facility. The staff education will be placed in a binder at the front desk and must be reviewed and signed by the staff member before returning to work. The staff member will sign a record of education to validate their understanding of the information presented in the binder. If the staff have any questions regarding the education, they will be instructed to contact the Administrator before signing the record of education. In the Administrator's absence, the Director of Nursing will answer questions regarding the education. The procedure for developing resident-centered care plans to provide guidance to staff to prevent residents with a history of substance abuse from introducing contraband into the facility or obtaining contraband in the facility will be achieved through education provided by the Administrator to the Social Services department staff on the importance of identifying residents with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	substance abuse disorders and assessing their risk of introducing drugs/contraband and obtaining drugs/contraband while in the facility. This risk assessment is documented in the resident chart in the Social Service Initial Interview for SMI/Substance Abuse Disorder (SS) assessment. This risk assessment must be used by the social services staff to develop a resident-centered care plan to address the potential risks of the resident introducing drugs/contraband into the facility and obtaining contraband/drugs while in the facility. Care plan interventions will be based on the resident's personal risk factors and coping mechanisms and may include but are not limited to efforts outlined in the facility policy for Alcohol/Substance Use/Abuse such as outside treatment services, acute/active treatment, sobriety counseling, or aftercare interventions. The effectiveness of the care plan must be reviewed quarterly and with changes in condition and updated as indicated. A binder will be placed at each nurse's station with a list of residents with substance abuse disorders as well as information on the resident-centered interventions for preventing them from obtaining contraband while in the facility. These binders will be updated by the social services department weekly and with resident changes in condition. This education will begin on [DATE] and will be completed [DATE]. Upon completion of this education, social services staff will sign a record of continuing education to confirm their understanding and knowledge of the topics presented. This (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	education will be presented to new hire social services staff upon hire and will be reviewed with all social services staff annually. Agency staff is not utilized in the social services department. There are currently no social services staff on leave of absence or vacation. There have been no updates to facility policies. 3. A system to supervise residents from obtaining contraband and from having or obtaining illicit drugs in the facility will be achieved through staff education. The Administrator will educate staff including registered nurses, licensed practical nurses, CNAs, social workers, activity staff, security guards, housekeeping staff, dietary staff, maintenance staff, reception staff, human resources director, and business office manager on the facility standard for providing adequate supervision for residents with substance abuse disorders to prevent them from obtaining contraband/ drugs. This education includes a review of the facility policy for safety and supervision which focuses on ensuring a facility-oriented approach to safety to address risks for groups of residents including residents with substance abuse disorders/history. Education will discuss the importance of identifying safety risks and environmental hazards on an ongoing basis. Staff will be educated that resident supervision is a core component of resident safety and that the type and frequency of supervision are determined by the individual resident's needs. Staff must intervene immediately whenever an unfavorable event between residents, staff, or visitors is noticed. Staff must decrease (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	safety hazards as much as possible and provide redirection when necessary. The education will review the facility's procedure for staff to

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 Based on interviews and record reviews, the facility failed to follow their physician visit policy and ensure the attending physician conducted face-to-face visit within the first 30 days of admission and/or at least once every 60 days. This affected six of six residents (R7, R15, R16, R18, R19, and R21) reviewed for physician visit. Findings include: On [DATE] at 3:26 PM, V46 NP (Nurse Practitioner) stated that V46 has been seeing residents at this facility since 2016. V46 stated that V54 (Attending Physician) and V46 document visits in the resident's electronic medical record. V46 stated that sometimes V54 does paper charting and note is uploaded into the resident's medical record. V46 stated that V46 is unable to find any recent notes by V46 or V54 in R15's medical record. V46 stated that V46 believes R16 was seen last month by her and V54. V46 was unable to find visit note in R16's medical record. V46 stated that she doesn't think R16's chart has been updated with notes yet. V46 stated that it is important for physician/NP notes to be uploaded into the resident's medical record timely to manage the care of the resident. When questioned if one month would be considered timely for uploading documents, V46 responded 'no'. V46 was unable to find visit notes for R19 or R21. V46 stated that she is not familiar with R7 or R18. On [DATE] at 12:20 PM, V54 (Attending Physician) stated that V54 documents face-to-face visits in the resident's electronic medical record. V54 stated that V54 comes to the facility frequently to see his residents. V54 stated that sometimes V54 does paper charting after the visit and gives note to facility staff to upload into the resident's electronic medical record. V54 stated that sometimes he is unable to chart in the facility's computer system because of technical issues with their computer system. V54 stated that notes are important and should be uploaded into the resident's medical record immediately but definitely within one month of receiving the notes. 1. R7's medical record notes diagnoses including, but not limited to, deep tissue injury of left ankle, pressure ulcers, sepsis, protein-calorie malnutrition, pneumonia, colostomy, emphysema, dementia, respiratory failure, anxiety disorder, heart failure, major depressive disorder, chronic obstructive pulmonary disease, and atrial fibrillation. R7 was admitted to this facility on [DATE]. R7 was hospitalized [DATE]-[DATE]. R7 was admitted into hospice care on [DATE]. R7 expired on [DATE]. R7's medical record notes V54 conducted face-to-face visits with R7 on [DATE], [DATE], and [DATE]. There is no documentation found in R7's electronic medical record noting V54 conducted face-to-face visit with R7 within 30 days of R7's admission to this facility on [DATE] or within 30 days of re-admission to this facility on [DATE]. On [DATE] at 8:55 PM, V1 (Administrator) presented documentation via email of a face to face visit with R7 dated [DATE]. This document does not contain any identifying information for this facility or for V54. This document was not found in R7's medical record on [DATE] or at any time previously during this survey. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R15's medical record notes diagnoses including, but not limited to, anxiety disorder, dementia, moderate protein-calorie malnutrition, atrial fibrillation, insomnia, urinary retention, hypothyroidism, scoliosis, gastrointestinal bleed, bipolar disorder, and cardiac pacemaker insertion. R15 was admitted to this facility on [DATE]. R15 was hospitalized [DATE] - [DATE], ,d+[DATE] - ,d+[DATE], , d+[DATE] - ,d+[DATE], and ,d+[DATE] - ,d+[DATE]. R15 was admitted into hospice care on [DATE]. There is no documentation noting V54 conducted any face-to-face visits with R15 between [DATE] to [DATE]. There is no documentation found in R15's electronic medical record noting V54 conducted face-to-face visit with R15 within 30 days of R15's re-admission to this facility on [DATE] or [DATE]. On [DATE] at 9:24 AM, V1 (Administrator) presented documentation via email of a face to face visit with R15 dated [DATE] and [DATE]. These documents do not contain any identifying information for this facility or for V54. These documents were not found in R15's medical record on [DATE] or at any time previously during this survey. 3. R16's medical record notes diagnoses including, but not limited to, stroke with hemiplegia (paralysis) affecting left non-dominant side, diabetes, and insomnia. R16 was admitted to this facility on [DATE]. R16's medical record notes V54 conducted face-to-face visits with R16 on [DATE], [DATE], and [DATE]. There is no documentation found in R16's electronic medical record noting V54 conducted face-to-face visit with R7 within 30 days of R7's admission to this facility on [DATE]. On [DATE] at 8:55 PM, V1 (Administrator) presented documentation via email of face to face visits with R16 dated [DATE], [DATE], [DATE], [DATE], and [DATE]. These documents do not contain any identifying information for this facility or for V54. These documents were not found in R16's medical record on [DATE] or at any time previously during this survey. 4. R18's medical record notes diagnoses including, but not limited to, right femur fracture, protein-calorie malnutrition, dysphagia, chronic ulcer of left foot, history of falling, dementia, chronic obstructive pulmonary disease, schizophrenia, major depressive disorder, insomnia, and peripheral vascular disease. R18 was admitted to this facility on [DATE]. R18 was hospitalized [DATE]-[DATE] and ,d+[DATE]-,d+[DATE]. R18's medical record notes V54 conducted face-to-face visits with R18 on [DATE], [DATE], and [DATE]. There is no documentation noting any face-to-face visits took place between [DATE] and [DATE]. 5. R19's medical record notes diagnoses including, but not limited to, chronic venous ulcer of right lower leg, right below the knee amputation ([DATE]), major depressive disorder, schizoaffective disorder, iron deficiency anemia, chronic obstructive pulmonary disease, and heart failure. R19 was admitted to this facility on [DATE]. R19 was hospitalized [DATE]-[DATE], and ,d+[DATE]-,d+[DATE]. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R19's medical record, dated [DATE] - [DATE], notes V54 conducted face-to-face visits with R19 on [DATE], [DATE], [DATE], and [DATE]. There is no documentation found noting V54 conducted a face-to-face visit with R19 between [DATE] and [DATE] and between [DATE] and [DATE]. 6. R21's medical record notes diagnoses including, but not limited to, diabetes, history of falling, lack of coordination, stroke, pacemaker insertion, atrial fibrillation, aphasia, insomnia, depression, anemia, anxiety disorder, and congestive heart failure. R21 was admitted to this facility on [DATE]. R21 was hospitalized [DATE] - [DATE]. R21's medical record, dated [DATE] - [DATE], notes V54 conducted face-to-face visits with R21 on [DATE], [DATE], [DATE], [DATE], and [DATE]. There is no documentation found noting V54 conducted a face-to-face visit with R21 between [DATE] and [DATE] and between [DATE] and [DATE]. This facility's physician visit policy, reviewed [DATE], notes each resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and then at least every 60 days thereafter. Must be seen means that the physician must make face-to-face contact with the resident. If the physician dictates a progress note, a brief note should be entered into the record at the time of visit stating that dictation will follow. The dictated progress note should be received by the facility and filed in the medical record within 7 days.