

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 07/24/2025
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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their abuse policy by failing to investigate an allegation of misappropriation of resident's fund by another resident. This failure affected two of three (R4 and R6) residents reviewed for investigating residents' allegations of misappropriation of funds. Findings include: R4 is [AGE] years old admitted to the facility on [DATE], past medical history includes, but not limited to Osteomyelitis, other acute osteomyelitis left ankle and foot, acquired absence of other left toes, iron deficiency anemia, paranoid schizophrenia, moderate protein calorie malnutrition, unspecified open wound left lower leg, prediabetes, delusional disorders, chest pain, etc. On 7/14/2025 at 11:30AM, R4 was observed in her room, alert and oriented and said that she was sent to the hospital because she had an argument with another resident (R6), R4 stated that R6 stole from her, she used R6's phone to order food one time and R6 ended up making numerous charges to R4's credit card. R4 added that her POA has the bank statement that shows all the charges. The staff did not want to get her money from R6, but the nurse was trying to give her a shot. R4 said that she refused, but the staff was still coming to her with the needle, so she spat on his face, that's the only way she can get him off her, and they sent her to the hospital. R6 is [AGE] years old and have resided at the facility since 3/15/2025, past medical history includes Pathological fracture, hip, unspecified, encounter for fracture with routine healing unspecified fracture of right calcaneus, Benign prostatic hyperplasia without lower urinary tract symptoms, cocaine dependence with withdrawal, major depressive disorder, essential primary hypertension, paroxysmal atrial fibrillation, etc. On 7/14/2025 at 12:05PM, R6 said that he used to be on the third floor, he moved to the first floor a couple of days ago after he had an argument with a lady on the third floor (R4). R6 denied physically assaulting R4 but had a verbal altercation with her. One day, R4 asked to use R6's cell phone, R6 informed R4 that she can only send text, she cannot make a call because his phone bill has not been paid. R4 went out and later came back to his room and offered to pay his phone bill, R4 gave R6 her credit card and he paid \$300.00 to the phone company. Later R4 told him that the phone company charged her \$500.00, R6 is not sure maybe \$300.00 was the amount due and \$500.00 was the total bill. R6 stated that since R4 paid for his phone, she always takes the phone and keeps it with her most of the time and uses it to make calls. R6 admitted that R4 has used his phone to order food and he did not realize that her card information was saved on his phone. He added that there were 2 additional charges, one for \$199.00 that R6 said he is not sure who made it, when he went home for the 4th of July, his family may have used his phone, he did not realize that R6's credit card number was saved on his phone. There was a \$100.00 charge from the phone company but R4 cancelled that one. Surveyor asked R6 if he reported this to any staff and he said, everyone is aware, including the social worker. On 7/15/2025 at 1:40PM, R6 said that his cell phone was broken by R4 the day they were involved in an altercation, he filled a grievance for his phone, but the social worker said that his phone will not be replaced by the facility. R6 had the phone with him and showed his phone to the surveyor, and it was noted that the screen was all shattered. R6 added that he cannot make calls with the phone due to the damage. Review of medical record did not show any documentation of the incident in either resident's record, or the reason R6 was moved to the first floor. Facility did not initiate any investigation of the allegation of misappropriation of resident's fund until the complaint investigation was initiated, though both residents stated that everyone one was aware that R4 accused R6 of stealing her money. On 7/14/2025 at 1:31PM, V14 (PSRAD) said that R6 was moved to the first floor because him and his girlfriend were not seeing eye to eye, they had a back-and-forth argument, but V14 is not sure what it was all about. R14 said that she was on the floor to see another resident when she heard R4 and R6 arguing, she tried to find out what was going on but R4 told her to mind her business, that the argument is between her and her boyfriend. R4 got aggressive with all the staff, code yellow was called and R4 was sent out to the hospital on 7/7/2025 due to aggression towards staff. V14 was asked if she spoke to R6 to find out what the argument was about, and she said no. Care plan initiated on 7/9/2025 for R4 by V14 states the following: Resident has a history of problems with money management, related to: Compromised decision making., Compromised judgment., This money management problem is manifested by getting into altercations with peers concerning borrowing, lending money. R4 presents with poor money management as evident by her offering money and to pay for/ buy things for staff and peers and later accuse them of stealing her money. On 7/15/2025 at 11:59AM, V14 was presented with the above care plan that she initiated for R4 two days after the altercation between R4 and</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to secure the physical environment (window) in R1's room and implement appropriate precautions for a resident with a history of elopement risk, high suicidal risk, high risk per criminal background/ behavioral history, and assessed as being unsafe in the community unsupervised for one resident (R1) of three residents reviewed for elopement. This failure resulted in R1 removing the stationary window brackets that prevent the window from opening in his room, jumping out of the window, and eloping through the open back gate of the facility undetected by staff. The immediate jeopardy began on 7/3/25 at 10:28 PM, when R1 removed the stationary window brackets that prevent the window from opening in his room, jumped out of the window, and eloped through the open back gate of the facility undetected by staff. V3 DON Director of Nursing and V27 Regional Director of Operations were notified of the immediate jeopardy on 7/17/25 at 2:42 PM. The surveyor confirmed by interview and record review that the immediate jeopardy was removed on 7/24/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1 is a [AGE] year old resident with diagnoses that include Bipolar Disorder Severe with Psychotic Features, Delusional Disorder, Suicidal Ideation, Suicide Attempt, Major Depressive Disorder, Psychosis, Schizoaffective Disorder, Violent Behavior, and Attention Deficit Hyperactivity Disorder. On 7/9/25 at 9:49 AM, V5 Family Member was inquired of R1. V5 said, I was told R1 unscrewed the window screws with a fork and jumped out the window of his room on 7/3/25 during the night. I was notified later that night. R1 hasn't been found. R1 sent a text message to his father and I from different phones saying he wants to die. He won't go to the hospital or tell us his location. He wants to care for himself. He has Bipolar with Schizoaffective Disorder. He tried to commit suicide before in jail, he jumped headfirst from the balcony. On 7/9/25 at 10:45 AM, upon observation R1's room is locked when attempting to enter. V6 Maintenance Director arrived to open the room for this surveyor. V6 said, It's a one person room so since R1's things are here I just locked it. R1 has a private room three doors from the nurse's station. Upon entrance to the room, it appears to be organized, there are food items, R1's identification card, and phone charger are on the bed. There are 2-3 bags of clothing stacked up in the left corner in a laundry basket. There is one large window with 3 windowpanes facing the back of the facility. V6 moved the center windowpane into the open position it was in when he arrived in the room after R1's elopement. V6 said, I came in on the of July 4th day shift. His room was a wreck. His clothes and food were all over the floor. The middle window was open and slide to the right. This part of the window isn't supposed to open, it's stationary. R1 broke the stoppers off the window. Upon observation, the window screws at the top are bent and V6 opened the middle windowpane and slide it over to the right as it was when he found it. The middle windowpane appears to have been dislodged from the window frame from the top allowing it to become unsecured and opened. On 7/9/25 at 11:08 AM, V6 escorted this surveyor to the backyard area of the facility. Upon entrance to the backyard there is a wooden fence that is secured by a lock that was opened by V6. There are 2 cameras on the back of the building facing the yard area. Under R1's window are pieces of a broken fence on the ground. There is a basement level window beneath R1's first floor window. V6 measured the space from R1's window to the ground which measured a 9-10 foot drop from the 1st story window. The wooden fence was observed to be intact. There is another gate entrance on the east side that is not secured. V6 said, R1 must have jumped the fence. On 7/9/25 at 11:24 AM, V7 RN Registered Nurse was inquired of R1. V7 said, R1 always isolates himself. If I ask how he is, he can't answer correctly. He'll say something off the topic. R1 did get out the building before. I had an instance when a CNA (Certified Nurse Assistant) opened the ramp door for a family member, and he ran in front of them into the parking lot. We got him back in. He only had a day pass if the family requested, and they had to pick him up here. I came in on July 4th 7AM to 3PM shift. I was told in report R1 eloped on 3PM to 11PM shift, they looked for him and called the police. On 7/9/25 at 11:50 AM, V9 Restorative CNA said, I was here on July 3rd, on 3PM to 11PM shift. I came by to get the linen bin by his room and his door and window was open. I checked the bathroom, and he was gone. I ran to the nurse's station and called a code pink. Staff went outside and police were called. I didn't see anything on the windowsill. I saw him last around 10:15 PM just in his room. On 7/9/25 at 12:22 PM, V11 CNA was inquired of R1. V11 said, I worked 3PM to 11PM. R1 is quiet and stays to himself. I checked on him during rounds and mealtimes. He ate his own food in his room. Closer to the end of the shift V9 CNA and I peeked in his room</p>		