

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 09/04/2025
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on the interview and record review, the facility failed to comply with privacy and confidentiality requirements when delivering mail to residents. This applies to 1 of 4 residents (R2) reviewed for privacy and confidentiality with mail delivery in a sample of 4. The findings include: On 9/2/25 at 12:05 PM, R2 stated, The facility received my card through the mail, and I don't know why they left my mail under my pillow while I was admitted to the hospital. Somebody stole my card and used it in the neighborhood store. On 9/3/25 at 9:10 am, V6 (Social Service Director) stated, Activity staff are usually responsible for delivering the mail to residents. If a resident is not present, they are required to give the mail to social services for secure storage. I cannot explain why, in this instance, the activity staff left the mail under R1's pillow when she was not present. The correct procedure is to return the mail to me for safekeeping, not to leave it in the resident's room. On 9/3/25 at 12:20 PM, V9 (Activity Director) stated, I honestly do not remember the date I delivered R2's mail by placing it under her pillow. Typically, we hand mail directly to residents. In this case, I was unaware that R2 was out of the facility, which is why I left the mail under her pillow instead of giving it to social services for secure storage, as is required when a resident is unavailable. The facility presented undated mail delivery policy document: The facility supports each resident's right to send mail and to receive mail in a timely manner in accordance with applicable state and federal regulations.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0602</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its abuse prevention policy by not protecting a resident from financial exploitation. This failure resulted in mental anguish and helplessness among 1 of 4 residents (R2) reviewed for theft and abuse in a sample of 4. The findings include: R2 is a [AGE] year-old female who was admitted on [DATE], and is independent in cognitive skills for daily decision-making, as per the Minimum Data Set (MDS) dated [DATE]. On 9/2/25 at 12:05 PM, R2 stated, I originally had \$1200 in my account, and I ran out \$800 out of \$1,200. I didn't give my bank card to anyone. Someone stole my card. The facility received my card through the mail, and I don't know why they left my mail under my pillow while I was admitted to the hospital. Somebody stole my card and used it in the neighborhood store. I am worried about my financial security here, and I don't know what to do. I didn't authorize anybody to buy stuff for me. When I returned from the hospital, I noticed charges on my card that I did not recognize. I called my bank, and they assisted me in making a report on these fraudulent charges. It was so stressful for me to call the bank and file a police report. A review of the facility's reportable incident dated August 15, 2025, showed that on August 22, 2025, police brought a picture of a person leaving a store where R2's card was used. The person in the picture appeared to be V5 (Certified Nursing Assistant/CNA), an employee of the facility. The police and facility administrator questioned V5 about taking the card, which V5 denied having done. As a result, V5 was immediately suspended pending the outcome of the investigation. A review of the police report with status date 8/20/25 documents that the police contacted the bank, and the bank confirmed multiple unauthorized transactions and withdrawals on R2's bank card by V5. On 9/2/25 at 11:45 AM, V6 (Social Service Director) stated, Our investigation found a significant amount of money missing from R2's credit card. We interviewed V5 (CNA), who claimed that R2 had requested him to purchase items at the store, but R2 reported unrecognized charges. Even if a resident request such purchases, staff are not authorized to make them. Based on this, V5 was suspended, though I am not certain about his current termination status. On 9/2/25 at 11:50 AM, V7 (Human Resource Director) stated, V5 was previously reprimanded for violating the uniform code. In this incident, V5 purchased items at a store using R2's card, allegedly at R2's request, but this was outside his job duties. As a result, we decided to terminate V5. I have been trying to reach him by phone to complete the termination, but he has not responded. Originally, he was suspended, and we are now moving to terminate him. On 9/3/25 at 12:20 PM, V9 (Activity Director) stated, Honestly, I don't remember the date I delivered R2's mail under her pillow. We usually deliver mail to residents' hands. In this specific scenario, I didn't know that R2 was out of the facility, and that's why I left it under the pillow. If the resident is not there, I should have given it to social services to securely store. On 9/3/25 at 11:25 AM, V1 (Administrator/Abuse Coordinator) stated, We provide abuse in-service on a quarterly and as needed. The residents have the right to be free from abuse. A review of the facility presented an abuse prevention policy dated 01/24 document: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment.</p>		