(X6) DATE

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLE	ETED	
IL6012835		B. WING		C 01/16	C 01/16/2025	
			NEPIN DRIV	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga 2570129/IL183790	ation:				
S9999	Final Observations		S9999			
	Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care					
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal					
iii. D	tment of Public Health		J.			

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/20/25 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6012835	B. WING			C 16/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DENIMIC	V NUDEING AND DEI	3401 HEN	NEPIN DRIV	E		
RENWIC	K NURSING AND REI	JOLIET, I	L 60435			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	care needs of the re	esident.				
		care-giving staff shall review ble about his or her residents' care plan.				
	 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 					
	These Regulations	are not met as evidenced by:				
	Based on interview and record review, the facility failed to ensure a resident was positioned safely in bed for cares. This failure resulted in R1 falling and sustaining fractures of her right femur and right tibia, and a right knee dislocation. This applies to 1 of 3 residents (R1) reviewed for safety/falls. The findings include: R1's Face Sheet showed she was admitted to the facility on 10/14/22, and her diagnoses include hemiplegia and hemiparesis following a cerebral infarction (affecting right dominant side), rheumatoid arthritis, polyneuropathy, obesity, and chronic pain.					
	The facility's 1/3/2025 Final Report for R1's 12/31/24 fall incident showed "Occurrence					

Illinois Department of Public Health

STATE FORM 5899 5VA311 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		C		
		IL6012835	B. WING			6/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENWIC	K NURSING AND REI	-IAR	INEPIN DRIV L 60435	Έ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	WICK NURSING AND REHAB JOLIET, IL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999			

Illinois Department of Public Health

STATE FORM 5899 5VA311 If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		A. BOILDING.			C		
		IL60	12835	B. WING		01/	16/2025
NAME OF PROVIDER OR SUP	PLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENWICK NURSING AN	RE	НАВ		INEPIN DRIV L 60435	E		
PREFIX (EACH DEFI	SUMMARY STATEMENT OF DEFICIENCIES			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
stated she reasome cream abut she could finally understated turned armoving, and secould not hold stated R1 had she guessed and she begathat she had tother staff meno one was at the country of the bed in the property of the country of the bed in the property of the country of the country of the bed in the country of the	CK NURSING AND REHAB 3401 HENI JOLIET, IL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999				

Illinois Department of Public Health

STATE FORM 5899 5VA311 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6012835	B. WING			C 16/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
RENWIC	K NURSING AND REI	HAB TO THE	NNEPIN DRIVE	Ē		
	OLIMANA DV. OTA	<u> </u>	IL 60435			0.50
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	femur fracture, and fracture.	right periprosthetic tibia				
	Left and Right two-ability to roll from ly side and return to ly 12/25/24 until 12/37 charting had 17 ent "Dependent- Helpe Resident does non activity. Or the ass required for the res R1's weight summa 12/26/24 was 342 p R1's MDS (MDS/M) 10/25/24 showed R extremity impairme	Care (POC) charting for "Roll person assist" regarding "the ing on back to left and right ying on back on the bed" from 1/24 was reviewed. R1's POC ries, with 16 entries as r does ALL of the effort. e of the effort to complete the istance of 2 or more helpers is ident to complete the activity." ary showed R1's weight on bounds. Sinimum Data Set) dated in had upper and lower on one side of her body. Sowed R1 used substantial to				
	maximum assist with rolling side to side while in bed. R1's 7/10/24 Nursing Rehab Bed Mobility care					
	plan showed a Focileft to right while in staff participation" a for the care plan she able to do one p	us for "Resident to turn from bed with assistance x(times)2 and the frequency. The "Goal" owed "Resident with a goal to erson assist for bed mobility." or the goal was 7/10/24, and				
	stated R1 should hat turning and repositi hemiplegia. V4 stat contribute to R1's la was documented as	2 PM, V4 (MDS Coordinator) ave had two people with oning due to her size and her ed those two factors ack of mobility. V4 stated R1 is being dependent in POC, hould have two people for				

Illinois Department of Public Health

STATE FORM 5899 5VA311 If continuation sheet 5 of 6

ILEG 12835 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE 340	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE JOLIET, IL 60435 [X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 5 repositioning and toileting hygiene in bed. R1's second hospital Consult Initial Report dated 01/01/25 "Patient stated she 'kept telling them that she was too close to the edge.' Right upper extremity with mild wrist and finger contractures likely chronic from [cerebrovascular accident] with residual right sided deficits. Right leg is extremely rotated. Right knee is swollen and diffusely tender to palpitation. Patient underwent open reduction of the right prosthetic knee with application of a short leg splint"				B W/N/O			
RENWICK NURSING AND REHAB 3401 HENNEPIN DRIVE JOLIET, IL 60435 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 5 S9999			IL6012835	B. WING		01/1	6/2025
Continued From page 5 Continued From page 5 Continued From page 10 Continued From page 20 Continued From page 3 Continued From page 40 Continued From page 5 Continued From page 5 Continued From page 5 Continued From page 60 Continued From page 7 Continued From page 8 Continued From page 8 Continued From page 9 Continued From page 9 Continued From page 10 Consult Initial Report dated Consult Initial Report dated Consult Initial From that she was too close to the edge. Right upper extremity with mild wrist and finger contractures likely chronic from [cerebrovascular accident] with residual right sided deficits. Right leg is extremely rotated. Right knee is swollen and diffusely tender to palpitation. Patient underwent open reduction of the right prosthetic knee with application of a short leg splint"	NAME OF	PROVIDER OR SUPPLIER					
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 5 repositioning and toileting hygiene in bed. R1's second hospital Consult Initial Report dated 01/01/25 " Patient stated she 'kept telling them that she was too close to the edge.' Right upper extremity with mild wrist and finger contractures likely chronic from [cerebrovascular accident] with residual right sided deficits. Right leg is extremely rotated. Right knee is swollen and diffusely tender to palpitation. Patient underwent open reduction of the right prosthetic knee with application of a short leg splint"	RENWIC	K NURSING AND REI	IAR		/E		
repositioning and toileting hygiene in bed. R1's second hospital Consult Initial Report dated 01/01/25 "Patient stated she 'kept telling them that she was too close to the edge.' Right upper extremity with mild wrist and finger contractures likely chronic from [cerebrovascular accident] with residual right sided deficits. Right leg is extremely rotated. Right knee is swollen and diffusely tender to palpitation. Patient underwent open reduction of the right prosthetic knee with application of a short leg splint"	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETE
	\$9999	repositioning and to R1's second hospita 01/01/25 " Patient that she was too clo extremity with mild likely chronic from [residual right sided rotated. Right knee to palpitation. Patien of the right prosthet	al Consult Initial Report dated to stated she 'kept telling them use to the edge.' Right upper wrist and finger contractures cerebrovascular accident] with deficits. Right leg is extremely is swollen and diffusely tender in underwent open reduction ic knee with application of a	S9999	DELIGITION		

6899

Illinois Department of Public Health STATE FORM

5VA311 If continuation sheet 6 of 6