STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055616	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARC JOLIET	222 NORTH HAMMES , JOLIET, Illinois, 60435

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S0000	Initial Comments Facility Reported Incident of 7/28/2025, 2598769 – F689 cited	S0000		09/04/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General	S9999		09/04/2025

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

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S9999	Continued from page 1 t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidence by: Based on observation, interview, and record review, the facility failed to safely transfer a resident from the bed to the chair. This failure resulted in R4 experiencing a right humeral neck fracture when the mechanical lift R4 was attached to tipped over and R4 struck the wall in her room. This applies to 1 of 3 residents (R4) reviewed for accidents in the sample of 33. The findings include: On August 25, 2025, at 10:25 AM, R4 was sitting in the chair with an ice pack over her right shoulder area. R4 said, "The other day I was up in the sling of the mechanical lift. The staff were transferring me to the dialysis chair from my bed when the entire [mechanical lift] tipped over with me in it. I slammed into the wall in my room hard, then the chair, and then the floor. My whole body ended up on the floor, still attached to the [mechanical lift]. I had very bad pain in my right shoulder. The [mechanical lift] machine also fell on one of the staff and she was pinned under the lift and my whole body. I went to the hospital, and they said I broke my arm by my shoulder." The facility's incident report dated July 28, 2025 shows, "Floor nurse entered the resident's room. Three CNAs (Certified Nursing Assistants) present. Resident was lowered to the floor by staff. Resident stated she hit her shoulder and head on the wall during transfer." The incident report continues to show R4 was alert and oriented to person, place, time, and situation. Predisposing environmental factors included clutter. Predisposing situation factors included incident occurred during staff assist with transfer to/from chair and the resident's weight." The EMR (Electronic Medical Record) shows R4 is a 44-year-old resident admitted to the facility on May 10, 2024 with multiple diagnoses including, end-stage renal disease, hypoxemia, right shoulder fracture, chronic respiratory failure, generalized anxiety	S9999		

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S9999	Continued from page 2 disorder, insomnia, panic disorder, dependence on renal dialysis, heart failure, Type 2 diabetes, major depressive disorder, neuropathy, and hypertension. R4's MDS (Minimum Data Set) dated August 8, 2025 shows R4 is cognitively intact, requires setup assistance with eating, partial/moderate assistance with oral and person hygiene, and is totally dependent on facility staff for all other ADLs (Activities of Daily Living). R4 is always incontinent of bowel and bladder. Dialysis documentation dated August 1, 2025 shows R4's weight as 385 pounds. On July 29, 2025, at 2:56 AM, V8 (LPN-Licensed Practical Nurse) documented the following progress note for R4 effective July 28, 2025, at 5:15 AM: "The writer was in the hallway and heard CNAs (Certified Nursing Assistants) yelling. The writer witnessed the resident on the floor attached to the [mechanical lift]. There were three CNAs present which stated the [mechanical lift] tipped over in the process of transferring the resident." V8's progress note was struck out by V18 (Restorative Nurse) on August 4, 2025 at 3:41 PM and labeled "incorrect documentation." On July 29, 2025, at 2:57 AM, V8 (LPN) documented the following progress note with an effective date of July 28, 2025, at 5:15 AM: "[R4] stated she hit her head and had right shoulder pain. She also stated the [mechanical lift] tipped over in the process of the transfer and she did not want to go to the hospital. V8's progress note was struck out by V18 (Restorative Nurse) on August 4, 2025 at 3:41 PM and labeled "incorrect documentation." On July 29, 2025, at 2:58 AM, V8 (LPN) documented the following progress note with an effective date of July 28, 2025, at 5:15 AM: "The writer called for help and called 911 for help getting the resident up from the floor… [R4] did not want to go to hospital. Writer explained since she hit her head she had to. The fire department arrived in 10 minutes and resident was taken to [local hospital] …" V8's progress note was struck out by V18 (Restorative Nurse) on August 4, 2025 at 3:41 PM and labeled "incorrect documentation." On August 25, 2025 at 2:01 PM, V8 (LPN) said, "I was notified by the CNAs that the [mechanical lift] tipped over and they lowered [R4] to the ground. The resident was still connected to the [mechanical lift] when I came to the room, and we had to disconnect her and lift the [mechanical lift] off of the CNA (V7). I assessed	S9999		

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S9999	Continued from page 3 [R4], and she complained of right shoulder pain." On August 25, 2025, at 6:09 PM, V8 (LPN) said, "I wrote very detailed notes of what I saw and what I assessed. My notes are accurate. I did not go into the EMR and strike out my notes and label them as incorrect documentation. My documentation is accurate as to what happened." On August 26, 2025 at 10:04 AM, V1 (Administrator) and V2 (DON-Director of Nursing) said V8's documentation was inadvertently struck out when changes were made to the risk management report attached to this incident. V1 (Administrator) said, "[V8's] notes are her story, and we will have to go back in and figure out a way to rewrite them." On August 25, 2025 at 1:36 PM, V7 (CNA) said, "I was getting [R4] up for dialysis on July 28, 2025. Another CNA was with me. We used the [mechanical lift] and raised [R4] up off the bed with the full-body sling attached to the [mechanical lift] to get her weight reading. We were pulling the legs of the [mechanical lift] out from under her bed and we turned the [mechanical lift] and [R4's] weight shifted, and the whole [mechanical lift] tipped over. It looked like the wheel had broken off and it pulled her and the lift over. As we were turning the [mechanical lift] the support legs of the lift were opening and closing. The support legs are supposed to stay in a locked position, but the shifter lever on the [mechanical lift] has been broken since I started working at the facility in January 2025, and we were not able to keep the legs in a locked position. [R4] was in the [mechanical lift] sling, attached to the [mechanical lift] when it tipped over. The [mechanical lift] tipped over and I was pinned between the wall, the resident, and the [mechanical lift]. [R4's] head hit the foot of the chair. Her right shoulder caught the corner of the wall in her room. [R4] never fell out of the [mechanical lift] sling. The bar that was holding all of [R4's] weight was completely in my rib cage. I still have bruises from the incident on my ribs. The support legs to the [mechanical lift] were completely pinned under the bed. There was too much clutter in the room, like cases of water, boxes of personal belongings, and bags of her stuff, to easily transfer her. There wasn't room for us to turn the [mechanical lift] because of the clutter. We had to stop and turn, stop and turn a little more, and when we went to turn the [mechanical lift] again, it seemed like the wheel broke and it just tipped over." On August 25, 2025 at 2:49 PM, V6 (CNA) said, "They	S9999		

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S9999	Continued from page 4 were getting [R4] up using the [mechanical lift], and the [mechanical lift] tipped over and the lift and [R4] hit the wall hard. The wall is what kept the whole [mechanical lift] and [R4] from falling all the way to the floor. [V7] (CNA) was pinned between the lift, the resident, and the wall. The [mechanical lift] with the resident still attached to the lift had to be lowered to the ground. The legs of the [mechanical lift] got stuck under the resident's bed. Even when the fire department came, it took six of them to get [R4] up off the floor. I have worked at the facility since May 2025, and that particular [mechanical lift] has been broken the whole time I have worked here. The support legs won't stay locked in a fixed position. They move in and out when you are trying to move the lift with the resident. They said it had been reported already that the [mechanical lift] needed to be fixed, so I never filled out a repair ticket." On August 25, 2025, at 6:16 PM, V5 (CNA) said, "They were transferring [R4] to the dialysis chair using the [mechanical lift]. I was holding the dialysis chair, and [V6] and [V7] were using the lift to get [R4's] weight reading from the lift before they started moving the lift away from the bed, with [R4] in the sling attached to the lift. The whole [mechanical lift] started to lean, and I was yelling to them to guide the lift, and I was screaming, it's leaning, it's leaning, but the resident was already in motion. The entire [mechanical lift] fell over with the resident attached to the lift, and the resident hit the wall hard, and it pinned [V7] (CNA) up against the wall. [R4] hit the corner of the wall, right by the bathroom door. [R4] hit the wall hard with her arm. We had to lower the resident and the lift to the floor at the same time, and the nurses came and started helping us move the chair and then we were able to lift the [mechanical lift] off of [V7]. It took a lot of paramedics to lift [R4] up the ground." R4's hospital records dated July 28, 2025 show, "This is a 44-year-old female who presents with trying to be transferred from bed to chair. They were trying to use the [mechanical lift] when the [mechanical lift] fell, and she fell and hit her back of the head on a chair and hit her right should on the chair. She is complaining of headache as well as right shoulder pain…" R4's right shoulder X-ray dated July 28, 2025 shows, "Findings are suggestive for a mildly impacted right humeral neck fracture." R4's right humerus X-ray, dated July 28, 2025 shows, "Impression: Impacted right humeral neck fracture."	S9999		

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S9999	Continued from page 5 On August 26, 2025, at 10:09 AM, V16 (NP-Nurse Practitioner) said, '[R4] was being transferred from the bed to the chair, and during the transfer, there was an arm injury, and she was sent to the hospital where she was found to have an arm fracture. She does not have fragile bones or any other medical condition that would have caused the fracture. It is safe to say the incident where the mechanical lift tipped over and she hit the wall caused the arm fracture." On August 25, 2025 at 10:53 AM, V13 (Maintenance Director) showed the mechanical lift device involved in R4's incident on July 28, 2025. The mechanical lift was sitting outside next to the facility's dumpster. V13 said the mechanical lift was taken out of service and placed in the trash. The mechanical lift device had a property identification sticker affixed to it identifying the lift as lift number "107." V13 demonstrated how the shifter lever on the mechanical lift is used to open and close the legs of the mechanical lift base for stability when lifting and transferring the resident. V13 said, "The shifter lever is broken. The shifter lever comes right off in your hand, which it is not supposed to do. Also, the shifter lever does not stay in the locked position because it is broken, so facility staff are unable to lock the legs of the base in place before moving the resident. The lift is so old, we just decided to throw it away after the incident." V13 demonstrated how the support legs of the mechanical lift would not stay in a locked position and how unstable the mechanical lift became when being moved with the support legs unlocked. V13 said the mechanical lifts in the facility are supposed to be inspected monthly. V13 said he started working at the facility on July 1, 2025 and had not inspected the mechanical lifts until July 30, 2025. V13 provided documentation to show the lift involved in the incident with R4 on July 28, 2025, lift number 107, had not been inspected since March 5, 2025. August 26, 2025 at 1:00 PM, V1 (Administrator) said facility staff should inspect the mechanical lift prior to using it and remove the mechanical lift from service if the mechanical lift is in need of repairs. The undated mechanical lift User Manual provided by V1 (Administrator) shows, the shifter handle must be locked when transferring the resident. Maintenance of the mechanical lifts should include an initial inspection, and monthly inspections and adjustments when used in an institutional setting. The facility's policy entitled Limited Lifting Resident Handling, revised on "1/25" shows: "Policy: This	S9999		

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S9999	Continued from page 6 facility will use mechanical lifting devices when lifting and moving the residents when indicated and as ordered by the physician. Purpose: To protect the safety and well-being of the staff and residents. Procedure: …4. Mechanical lift equipment shall undergo routine maintenance checks and be accessible to staff 24 hours a day. …8. The policy will be followed at all times. Failure to comply will result in disciplinary action at management's discretion." The facility's undated Validation of Competency – Total (Full Body) Mechanical Lift Transfer shows the facility's expected performance criteria. The Validation of Competency shows facility staff are expected to know a mechanical lift pre-operations check should be completed including, checking the weight limit of the mechanical lift and the sling size/style to verify they are appropriate for the resident, confirm the battery is charged, inspect the lift condition and check the operation, inspect slings for frays, tears, or other signs of wear, and state the reason and process for removing lift equipment and slings from service. The staff competency also shows facility staff are expected to know to clear a pathway to allow the lift to pivot and move freely. (B)	S9999		