

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2025
NAME OF PROVIDER OR SUPPLIER Parc Joliet		STREET ADDRESS, CITY, STATE, ZIP CODE 222 North Hammes Joliet, IL 60435	
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 - Actual harm 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** 36567 Based on interview and record review, the facility failed to supervise a resident with impaired cognition while drinking a hot beverage. This failure resulted in the resident spilling the hot beverage, sustaining burns to her bilateral thighs and was transferred to hospital for treatment of the same. This applies to 1 of 3 residents (R1) reviewed for accidents and supervision in the sample of 3. The findings include: R1's face sheet showed that R1 was admitted to the facility on [DATE] with multiple diagnoses including Multiple Sclerosis, Dysarthria and Anarthria, Hereditary Spastic Paraplegia, Muscle Wasting and Atrophy, Anxiety Disorder, Insomnia, Diseases of Spinal Cord. R1's quarterly MDS (minimum data set) dated February 28, 2025 showed that R1 was severely impaired in cognition and required supervision or touching assistance for eating. Facility Incident logs showed that R1 had a hot liquid burn on March 10, 2025. Facility discharge records and nurses progress notes showed that R1 was discharged to the hospital to the burn center on March 13, 2025. Hospital patient information records showed that R1 was admitted to Burn stepdown unit on March 13, 2025. Hospital Burn Attending Physician history and physical progress note dated March 14, 2025 included that R1 presents with 5% scald burns: full thickness wounds accounting for 1.5 TBSA [total body surface area] to bilateral thighs . Occupational Therapy Assessment at hospital dated March 14, 2025 included that R1 is a [AGE] year old female with diagnosis of Burn who presents impairments in range of motions, strength, gross motor coordination, fine motor coordination, bilateral coordination, activity intolerance, safety awareness, balance motor planning, manual dexterity and self help skills. Performance deficits include difficulty in ADLS [activities of daily living] including feeding. (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145221	Facility ID: 145221 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility Change of Condition progress note dated March 13, 2025 included as follows: Resident has a second degree wound and blister wound on both thigh that needs attention as resident has been refusing care . Assessment for the same showed to send to the hospital for further care. Facility nursing progress notes dated March 10, 2025 included as follows: Resident sitting in hallway across from nurses station after shower for monitoring at 1515 (3:15 PM) resident yelled out CNA (Certified Nursing Assistant) went to assist resident noted resident had spilled drinking cup over, CNA took resident to room to change wet clothing summons this writer to resident room, this writer noted both thighs were reddened with blistered area on bilateral thighs, wound care nurse informed area addressed per wound care protocol . On March 28, 2025 at 9:52 AM, V5 (Licensed Practical Nurse) stated that on March 10, 2025, she was R1's nurse and V6 (CNA) had brought R1 out to the nurses station after a shower and placed her in a geri (recliner with wheeled bases) chair and given her something warm to drink. V5 stated that it was around the change of shift in the afternoon. V5 stated that she believes that V6 had heated up some water with a tea bag and set it on a bed side table and R1 knocked it off. V5 stated that V6 took R1 to her room to change her wet clothes and that's when she noticed that the area around R1's upper thighs were reddened. V5 stated that she notified V3 (Wound Care Nurse) and since V3 was leaving for the day, she applied the treatment based on V3's suggestion and endorsed to the night nurse. On March 28, 2025 at 2:25 PM, V6 (CNA) stated that she works the afternoon shift on March 10, 2025 and the routine was that when she comes in she gets her assignments and gives residents their showers. V6 stated that she gave R1 a shower with the assistance of V13 (CNA) and after changing her, they transferred her to a geri chair and placed her by the nurses station. V6 stated that R1 was cold and asked for tea. V6 continued I made the tea by getting a tea bag from the kitchen and I got water from the faucet and heated to about 1 to 1 1/2 minutes and gave it to her on a bedside table [that was by the geri-chair]. I had to help other residents and I walked away to help V13 with the showers. When I was down the hallway in the 2400 unit, she said 'Ahh' and the nurse [V5] told me to check her. I bring her to the room and pulled out her pants and showed it [reddened area] to the nurse who applied some ointment. She [R1] is always a challenge and moves around. When asked, what cup she used to heat the water, V6 stated that it was a Styrofoam disposable cup. On March 28, 2025 at 10:12 AM, V3 stated that she was working as a floor nurse on March 11, 2025 and was asked to take a look at R1 while they were providing care. V3 stated Upon laying eyes on her, I can tell that it had blistered and the skin was pretty exposed. V3 clarified that there was a very large intact blister on one thigh/leg and on the other thigh/leg the blister was partially ruptured. V3 stated that the staff who were changing R1 told her that there was a dressing on the partial blistered area but R1 had ripped it off as she was very agitated which must have caused the blister to be ruptured. V3 also added that lately, the staff had to assist and cue R1 with eating, more so because of her mental than physical decline. On March 28,2025 at 12:45 PM, V7 (Restorative Aide) stated that R1 has good and bad days and that on some days she was able to feed herself and other days the staff provided assistance in eating. V7 added that R1 had a tendency to lean forward if she was tired or not feeling well. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On March 28, 2025 at 12:47 PM, V8 (CNA) stated that she has taken care of R1 and that for most part, R1 usually ate in the dining room by herself. V8 stated that R1 would sometimes spill food and drinks. On March 28, 2025 at 2:11 PM, V14 (R1's Power of Attorney) stated You don't give a person hot tea without a lid knowing her condition. This particular CNA [V6] knows her behavior. R1's restorative care plan dated January 20, 2023 showed that R1 has a self-care deficit (ADLs/Mobility) secondary to her diagnosis of multiple sclerosis and paraplegia. Interventions included intermittent supervision with meals and encourage to finish food for adequate nutrition, assist as needed. R1's nursing care plan revised January 15, 2023 showed that R1 demonstrates physical & emotional impairment secondary to neurological disease/damage caused by: multiple sclerosis and paraplegia. Interventions for the same included to provide assistive/adaptive devices to help the resident do as much for himself as possible. R1's behavior care plan initiated April 18, 2024 showed that R1 has potential to demonstrate physical behaviors or aggressive behaviors towards staff including yelling, knocking stuff down and throwing objects related to multiple sclerosis. Interventions included to assess and anticipate resident's needs		