STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parc Joliet	222 North Hammes Joliet, IL 60435

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident. This applies to 1 of 3 residents (R3) reviewed for resident-to-resident assault in the sample of 33. The findings include:On August 21, 2025 at 1:05 PM, R3 was lying in bed in his room. R3's right eyelid was closed/drooping, and some redness was noted on his cheek below his right eye. R3 said, I was punched in the eye by another resident. I don't know why he hit me. I went to the hospital. It doesn't hurt anymore. The EMR (Electronic Medical Record) shows R3 was admitted to the facility on [DATE] with multiple diagnoses including, cerebral infarction, hemiplegia and hemiparesis of the left side following cerebral infarction, asthma, abnormal gait and mobility, dysphagia, chronic kidney disease, delusional disorders, anxiety disorder, major depressive disorder, and anemia. R3's MDS (Minimum Data Set) dated May 15, 2025 shows R3 has severe cognitive impairment, requires supervision with eating, and substantial/maximal assistance with all other ADLs (Activities of Daily Living), including wheelchair self-propelling. R3 is frequently incontinent of bowel and bladder. On July 29, 2025, at 5:27 PM, V14 (LPN-Licensed Practical Nurse) documented the following progress note for R3: Writer was in the nursing station when I heard a fight going on down the hall. Writer ran down the hall, saw [R2] hit [R3] on the face. Writer quickly separated and brought the resident (R3) to the nursing station. Resident observed to have a skin tear. Area cleaned and dried. Resident in bed at this time. On July 29, 2025, at 10:45 PM, V15 (LPN) documented, Around 2030 (8:30 PM) CNA (Certified Nursing Assistant) reported to writer that [R3] was experiencing increased right eye pain and could not see out of eye. Writer evaluated the right eye, and it was noted that the eye had two small cuts underneath bottom eyelid and resident stated it hurt to open eye, so writer was not able to fully assess the eyeball. NP (Nurse Practitioner) notified at 2045 (8:45 PM) and [ambulance] transportation was called to have patient sent to ER (Emergency Room) for further evaluation and treatment. Hospital discharge paperwork for R3 dated July 29, 2025 at 9:47 PM shows the resident was seen in the ER for assault. You were seen in the emergency room after being punched in the face. The CAT scans are normal. You have a very small cut on your eye that does not need stitches. If you have worsening symptoms, you may return here at any time. On July 30, 2025, at 2:30 PM, V15 (LPN) documented, [R3] arrived back to facility via [ambulance] stretcher at 0220 (2:20 AM) . Writer assessed right eye and cut under eye needed no stitches according to physician at the hospital. Resident reported to have less pain after coming back from hospital but still struggling to open right eye. No other concerns were noted at this time. On July 30, 2025, at 9:12 AM, V16 (NP-Nurse Practitioner) documented, Routine visit s/p (status post) hospitalization. Asked to see [R3] for routine visit s/p hospitalization. [R3] was punched by another resident. Bruising noted in the periorbital area. Continue to monitor. The EMR shows R2 was admitted to the facility on [DATE] with multiple diagnoses including, metabolic encephalopathy, major depressive disorder, anxiety disorder, morbid obesity, opioid abuse, chronic pain due to trauma, impulse disorder, history of traumatic brain injury, lymphedema, and tremor. R2's MDS dated [DATE] shows R2 has moderate cognitive impairment, requires setup assistance with eating, oral and personal hygiene, supervision with toilet hygiene and transfers between surfaces, and partial/moderate assistance with showering, dressing, and bed mobility. R2 is occasionally incontinent of bowel and bladder. Multiple attempts were made to interview R2, including on, August 21, 2025 and August 25, 2025. R2 refused to be interviewed. A Petition for Involuntary/Judicial admission dated July 29, 2025 at 7:50 PM, and completed by V17 (LPN) shows, [AGE] year-old male named [R2], who is intermittently confused, became agitated and struck another resident in eye, causing skin tear/injury at 1727 (5:27 PM). On July 29, 2025 at 8:13 PM, V17 (LPN) documented, [R2] discharged to [hospital]. Reason for transfer: increased confusion, aggression, physical altercation. R2's hospital discharge documentation, dated July 29, 2025 at 8:36 PM shows: You were seen today for: agitation. You were seen in the emergency room for an episode of agitation and a fight. There are no signs of serious injury from the fight. There are no signs of serious psychiatric illness that would require any sort of inpatient admission. Your labs are normal. You are being discharged . On August 21, 2025 at 2:38 PM, V14 (LPN) said she was sitting at the nurse's station when R2 and R3 had an altercation at the end of the hall, including arguing and physical hitting. V14 continued to say, [R2] has been having a lot of behaviors. I saw the two residents struggling. The police came to the facility as well. V14 continued to say the nurse assigned to R2 (V17) was on break at the time of the incident and was not present on the resident floor. On August 25 2025 at 9:50

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(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. (continued on next page)

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses including, end-stage renal disease, hypoxemia, right shoulder fracture, chronic respiratory failure, generalized anxiety 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 [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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an accurate medical record regarding a resident's incident during a mechanical lift transfer. This applies to 1 of 3 residents (R4) reviewed for falls 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 [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses including, end-stage renal disease, hypoxemia, right shoulder fracture, chronic respiratory failure, generalized anxiety 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. 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 [R4], and she complained of right shoulder pain. On August 25, 2025, at 6:09 PM, V8's (LPN) struck out progress notes were reviewed with V8. Each entry was read out loud to V8 during the interview. V8 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 the incident on July 28, 2025. 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 27, 2025, at 12:25 PM, V18 (Restorative Nurse), The risk management report for [R4's] incident on July 28, 2025 was struck out by me. Initially, the nurse entered the information into risk management as a fall. I was told by the corporate consultant to strike out the incident and label it as inaccurate documentation because the incident was not considered to be a fall because the resident was intentionally lowered to the ground. I only struck out

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure mechanical lift devices are maintained in safe, operating condition, are routinely inspected, and removed from service when repairs are needed. This applies to 30 of 30 residents (R4-R33) reviewed for mechanical lift transfers in the sample of 33. The findings include:The facility provided a list of all residents residing in the facility who require the use of a mechanical lift device for transfers between surfaces. The undated list shows R4-R33 require the use of a full-body mechanical lift for transfers between surfaces. On August 25, 2025, at 9:50 AM, V2 (DON-Director of Nursing), and V1 (Administrator) said there was an incident at the facility on July 28, 2025 involving R4 and a mechanical lift. V2 said, The wheel on the [mechanical lift] buckled. It fell enough for [R4] to hit her shoulder on the wall and break a bone. On August 25, 2025 at 1:36 PM, V7 (CNA-Certified Nursing Assistant) 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]. 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. On August 25, 2025 at 2:49 PM, V6 (CNA) said, They were getting [R4] up using the [mechanical lift], and the [mechanical lift] tipped over and the lift with [R4] attached to it, hit the wall hard. 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 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 the facility, 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 the 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 do not stay in a locked position and how unstable the mechanical lift became when being moved with the support legs unlocked, and opening and closing as the mechanical lift was moved from one place to another. 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, after the incident involving R4. 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. V13 provided mechanical lift inspection/maintenance logs labeled 2025, with the mechanical lifts identified as 103, 105, 107, 108, 109, 110, 111, and 112. The inspection sheets show the last inspection date for the mechanical lifts was March 5, 2025. The months of April, May, June, July, and August were blank on each of the inspection sheets. An inspection of all mechanical lifts was completed with V13. Four mechanical lifts were identified, including one rental mechanical lift. V13 said he did not inspect the rental mechanical lift to ensure it was in good working order, and he was unable to say how long the facility had been using the rental mechanical lift. None of the mechanical lifts were labeled with identifiers that corresponded to the inspection logs provided by V13. An unlabeled mechanical lift was found in a common area of the second floor. V13 was unable to lock the mechanical lift shifter lever in place and said the mechanical lift was broken. V13 did not remove the mechanical lift from the resident floor or label the mechanical lift with a sign to indicate the mechanical lift should not be used. On August 25, 2025, at 11:53 AM, a general tour of the facility was completed with V2 (DON-Director of Nursing). Mechanical lifts were observed throughout the facility, in resident hallways and common areas, available for all facility staff to use. V2 said after the incident involving R4 and the mechanical lift, she asked V13 to inspect all mechanical lift devices and label each lift with an identifier to