

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/23/2025
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident was not physically abused by a staff. This applies to 1 of 10 residents (R6) reviewed for physical abuse in the sample of 10. The findings include: R6 was admitted to the facility on [DATE]. R6 had multiple diagnoses including bipolar disorder, conduct disorder, anxiety disorder, restlessness and agitation, and severe dementia with agitation, based on the face sheet. R6's admission MDS (minimum data set) dated October 1, 2025 showed that the resident was severely impaired with cognition. The same MDS showed that R6 required moderate to maximum assistance from the staff with most of her ADLs (activities of daily living). On November 21, 2025 at 11:28 AM, R6 was inside the first-floor dining room, her head resting on the dining table. R6 responds inappropriately when talked to. R6 was confused. Sitting beside R6 was V17 (CNA/Certified Nursing Assistant). V17 stated that the staff takes turn providing 1:1 supervision of R6 because the resident is very confused and would constantly attempt to get up and ambulate without assistance. The facility's initial report sent to the State Regulatory Agency, showed that on November 17, 2025 a Resident reported an allegation of staff member's conduct not meeting facility standards while providing care to resident [R6]. Alleged staff member was sent home pending investigation. Head-to-toe assessment completed. [Physician], POA (Power of Attorney) and police notified. Investigation was initiated. The facility's final report sent to the State Regulatory Agency on November 20, 2025 showed that on November 17, 2025 around 9:00 PM, R1 (another resident) reported to V16 (RN, Registered Nurse) that he was walking by R6's room and observed V14 (CNA, Certified Nursing Assistant) holding a pillow and that the pillow made physical contact with R6's face. R6 was immediately separated for safety and V14 was sent home pending investigation. The report documented that R6 was unable to recall any inappropriate situation occurring and was mentally and physically stable at baseline when interviewed. R6 had no skin abnormalities when assessed. R6 had no complaints of pain and mental anguish. R6 was evaluated by the in-house Nurse Practitioner and had documented that the resident had no apparent distress, was calm and cooperative. The report showed that the camera footage of the alleged incident was reviewed on November 17, 2025 at 9:40 PM and The footage did not show any improper staff behavior, CNA [V14] was not assigned to [R6], and was not present in her room at the time of the alleged incident. The report documented that the police arrived at the facility at around 9:50 PM and was shown the camera footage and deemed there was no further reason to investigate. On November 17, 2025 at 11:28 PM, V16 reported that according to R1, the alleged incident happened in the dining room earlier, around dinner time. The report documented that R1 was interviewed and stated that the facility has cameras, so he shouldn't need to make an official statement. V14 was interviewed by the facility and stated that she was in the dining room with R6, [R6] stood up from her wheelchair, and she saw that she was sitting on a pillow. [V14] grabbed the pillow to take it out due to it being a safety issue and when she did, [R6] also grabbed the pillow. [V14] said she let go of the pillow and then [R6] sat back down in her wheelchair. She said the pillow did not make contact with [R6]. V15 (CNA) was interviewed by the facility and stated that around dinner time, V14 came into the dining (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room while she (V15) was sitting behind R6 and [V14] came up, grabbed the pillow from the table, and the pillow made contact with [R6]. The report documented that the facility reviewed the dining room camera footage from November 17, 2025 and showed that at 6:19 PM, [R6] was sitting at the dinner table. [V15] was sitting behind her, and [R1] was standing nearby. [V14] approaches the table where [R6] is sitting, she grabs a pillow from the table, and the pillow makes contact with [R6]. The facility again called the police after the camera footage review and eyewitness interview to make another report. V14 and V15 were terminated by the facility due to failure to follow facility protocols and the abuse prevention program. The facility's final report concluded that, there is credible evidence that [V14] was holding a pillow, and that the pillow made contact with [R6]. On November 21, 2025 at 11:16 AM, R1 stated that on November 17, 2025 sometime at night, he reported to a male nurse that V14 (CNA) hit R6 on the face with a pillow and to look at the camera because he does not want to give an official statement. According to R1, the incident happened inside the dining room, around dinner time. R1 stated that V14 no longer work at the facility. On November 22, 2025 at 3:35 PM, V16 (RN) stated that on November 17, 2025 he started his shift at 7:30 PM, and between 8:00 PM and 8:30 PM while passing medications, R1 came to him and started asking him questions like, How would you feel if your family member was hit with a pillow by somebody at the facility? V16 stated that he asked R1 what he was talking about for clarification and during the conversation, R1 mentioned R6 and V14's (CNA) names but did not really explain what had occurred and/or gave further information but instead said that he will call the State. According to V16, upon hearing what R1 shared, he immediately called V2 (DON (Director of Nursing)) to report the potential abuse and because R1 did not give him full information, he (V16) assumed and reported to V2 that R1 saw V14 hit R6 with a pillow inside the resident's room. According to V16, he assessed R6 without any injuries or complain of pain and made sure that the resident was safe. V14 was sent home by V2 that night. V2 came to the facility and the police also came and talked to V2. During the same interview, V16 stated that at around 11:20 PM, after V2 and the police had left the facility, R1 again came to him and told him (V16) that he saw V14 hit R6's face with a pillow inside the dining room, earlier that night. V16 stated that after talking to R1 with more information, he immediately called V2 to report. On November 21, 2025 at 4:21 PM, V2 (DON) stated that she received a call from V16 (RN) on November 17, 2025 at 9:15 PM and was informed that R1 reported that he saw V14 (CNA) hit R6 with a pillow inside the resident's room. V2 instructed V16 to immediately assess R6 and to make sure that the resident was safe, and then she called V14 on her cellular phone. She asked V14 about the incident and she told V14 to go home and that she was suspended pending investigation of the alleged abuse. According to V2, she then called the police to make a report and then drove to the facility since it was only about five minutes away. V2 stated that when she arrived at the facility, she immediately reviewed the November 17, 2025 afternoon to nighttime hallway camera footage of where R6 resides, and she did not see V14 going to the said hallway or inside R6's room. V2 stated that when the police came to the facility on November 17, 2025, she showed the camera footage, and the police told her that they (police) have no further reason to investigate because V14 did not appear on the footage and the police left the facility. According to V2, when she talked to V14 prior to sending her home, she asked V14 if she hit R6 with a pillow, V14 denied ever hitting R6 with a pillow and stated that she was not assigned to R6, and she (V14) also did not work at the same hallway where R6 resides. V2 added that on November 17, 2025 at 11:28 PM, she again received a call from V16 and was informed that R1 again came to him and told him that the incident between V14 and R6 happened in the dining room, earlier that night. V2 stated that upon further investigation of the alleged abuse, V15 (CNA) stated on an interview that during dinner time on November 17, 2025, she was sitting behind R6 monitoring the resident, V14 came towards the table where R6 was sitting, V14 grabbed the pillow from the table and the pillow made contact with R6. According to V2, the facility also reviewed the dining room camera footage for November 17, 2025 and showed that V14 approached the table where R6 was seated, V14 grabbed the pillow from the table and the pillow made contact with R6. During the same interview, V2 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that V14 and V15 were terminated by the facility on November 20, 2025 after completion of the investigation. V15 was terminated because she did not report the abuse incident immediately and V14 was terminated because the abuse allegation was substantiated as confirmed by V15 and the camera footage. On November 21, 2025 at 4:09 PM, V1 (Administrator) stated that when the incident occurred between V14 (CNA) and R6 on November 17, 2025, she was on vacation. According to V1 after the facility's full investigation, V14 was terminated. The facility had reported the incident to the police and a copy of the camera footage, was also given to the police as part of the evidence because the facility had filed charges against V14 for physical abuse towards R6. V1 added that the facility would also report the incident to the State Nurse Aide Registry. On November 21, 2025 at 12:20 PM, V1 showed the first-floor dining room camera footage of November 17, 2025. During the observation of the footage, V1 zoomed to clearly see R6 sitting in her wheelchair inside the dining room, while V15 (CNA) was seated behind R6, assisting the resident to sit down when R6 attempted to stand. The footage showed that at 6:19 PM, R1 could be seen standing nearby. V14 (CNA) walked towards the table where R6 was seated. While V15 was present, V14 grabbed the pillow that was on the table and swung the pillow towards R6 hitting the resident's face, then V14 left. R6 remained seated. The facility's policy and procedure regarding Abuse Prevention Program dated January 2024 showed in-part, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. The policy showed, The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, mental, sexual or physical abuse; corporal punishment; and involuntary seclusion. The facility has a no tolerance philosophy; persons found to have engaged in such conduct will be terminated. The procedure under internal reporting and identification of allegations, showed that employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about or suspect to the administrator immediately or to an immediate supervisor.		