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	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parc Joliet	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to report a resident's injury of unknown origin within required timeframes.This applies to 1 of 3 residents (R1) reviewed for abuse concerns.The findings include:Camera footage from [DATE] showed around 7:35 PM, R1 and V4 (Certified Nursing Assistant) were standing in front of the elevators, the doors opened, and R1 pushed V4 into the elevator. The footage showed that V4 grabbed R1's right arm and then jerked R1's right arm, pulling R1 into the elevator. The footage then showed R1 was transported to the hospital around 8:01 PM. R1's [DATE] emergency room records showed that R1 arrived at the hospital with a swollen upper lip and dried blood on his lip. On [DATE] at 1:15 pm, V8 (CNA) said that she saw blood on R1's mouth after the incident but she did not know where the blood was coming from.On [DATE] at 2:48 pm, V3 (Nurse), who was R1's nurse at the time, said that she saw blood on R1's lip after the incident but she did not attend to or assess R1. R1's [DATE] Minimum Data Set showed that his cognition is severely impaired. R1's [DATE] 8:17 PM progress notes showed that R1 was being aggressive towards a nurse and a CNA and he was transported to the local community hospital for psychological evaluation. R1's [DATE] 1:08 AM progress note showed that R1 returned from the hospital. On [DATE] at 4:17 PM, V2 DON (Director of Nursing) said that she was not informed that R1 was found with blood on his mouth.On [DATE] at 4:30 pm V15 ADON (Assistant Director of Nursing) said that he was unaware of R1 having blood on his mouth.On [DATE] at 4:05 pm, V1 (Administrator) said that she did not investigate the incident involving R1 on [DATE]. The facility was unable to provide documentation that showed the facility notified the Illinois Department of Public Health that an investigation had been opened into the cause of R1's bloodied and swollen lip on [DATE]. The facility's 1/2024 Abuse Prevention Program policy showed V. Internal Reporting Requirements and Identification of Allegations. Employees are required to report any incident, allegation, or suspicion of potential abuse.they observe, hear about, or suspect, to the administrator immediately or to an immediate supervisor, who must then report it to the administrator.reports should be documented and a record kept of the documentation.The nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises, lacerations, or other abnormalities as they occur. The policy's section VIII. External Reporting showed 1. Initial Reporting of Allegations-.Public Health shall be informed that an occurrence of potential abuse.is being investigated. 2. Five-Day Final Investigation Report- within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation.will be sent to the Department of Public Health.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to investigate the cause of a resident's injury.This applies to 1 of 3 residents (R1) reviewed for unknown injury.The findings include:R1's 4/11/26 Minimum Data Set showed that his cognition is severely impaired.R1's 5/6/2026 8:17 PM progress notes showed that R1 was being aggressive towards a nurse and a CNA (Certified Nursing Assistant) and was transported to the local community hospital for a psychological evaluation.On 5/14/2026, the facility's camera footage of 5/6/26 from 4:00 pm to 8:05 PM was reviewed. The footage from 7:35 pm to 7:59 PM showed R1 was attempting to leave the facility by means of the elevator and the stairway and staff were intervening. The footage showed that around 7:35 PM, R1 and V4 CNA were standing in front of the elevators when the doors opened, and R1 pushed V4 into the elevator. The footage showed V4 grabbed R1's right arm and then jerked it, pulling R1 into the elevator. On 5/14/26 at 1:15 pm, V8 (CNA) said afterwards she saw blood on R1's mouth but she did not know where the blood was coming from.On 5/14/26 at 2:48 PM, V3 (Nurse), who was R1's nurse at the time, said that she saw blood on R1's lip after the incident but she did not attend to or assess R1. R1 was sent to the Emergency Room.R1's 5/6/2026 emergency room records showed that R1 arrived at the hospital with a swollen upper lip with dried blood present. R1's 5/7/2026 1:08 AM progress note showed that R1 returned to the facility. On 5/14/26 at 4:17 PM, V2 DON (Director of Nursing) said that she was not informed that R1 had blood on his mouth and did not investigate any injury to R1. On 5/14/26 at 4:30 PM, V15 ADON (Assistant Director of Nursing) said that he was unaware of R1 having blood on his mouth and did not investigate R1 for an injury.On 5/14/26 at 4:05 PM, V1 (Administrator) said that she did not investigate the incident involving R1 on 5/6/26. The facility was unable to provide any documentation of an investigation conducted for R1 that related to injuries incurred during the 5/6/2026 incident.The facility's 1/2024 Abuse Prevention Program policy showed .Incidents, will be reviewed, investigated and documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of residence property occurred, was alleged or suspected. Incidents or allegations.will be reviewed by the administration and shall be investigated For resident injuries not involving an allegation of abuse or neglect the administrator will appoint a person to gather further facts to make a determination as to whether the injuries should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both the following conditions are met: the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury or the location of the injury. If the cause of an injury of unknown, the person gathering facts will document the injury.The investigator will attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable.