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	06/24/2026

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 0600 Level of Harm - 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 observations, interviews and record reviews, the facility failed to protect a resident's right to be free from abuse. This failure applies to 1 of 3 residents (R1) reviewed for abuse. This failure resulted in R1 experiencing inappropriate physical assault when a visitor entered her room, unzipped his pants, and placed an item into her mouth and resulted in R1 experiencing inappropriate physical contact and assault. The findings include: R1's electronic medical records show she is a [AGE] year-old female with diagnoses and conditions including early onset Alzheimer's disease, anxiety disorder and impaired communication who was admitted to the facility May 11, 2024.On June 23, 2026, at 11:00 AM, R1 was lying in her bed in her room unable to speak, with her upper and lower extremities contracted. R1 was clinching her teeth and opened her eyes wide in response when spoken to. R1 had an anxious expression on her face while observing the surveyor walking near or around her bed.R1's current care plan-initiated May 13, 2024, shows she is totally dependent on staff for all activities of daily living, requires two staff to turn and reposition, is non-ambulatory, and is non-verbal.On June 24, 2026, at 9:54 AM, V13 (Registered Nurse/Restorative) and V14 (Restorative Aide) said R1 is fully dependent on staff for mobility and all activities of daily living, is unable to move at all on her own. V13 and V14 said R1 is fully contracted in her upper and lower extremities, is non-verbal, and clinches or grinds her teeth frequently. V14 said no oral devices are used by R1.On June 23, 2026, at 12:20 PM, The facility's camera footage showed on June 10, 2026, at 2:20 PM, V7 (Visitor) entered the facility, approached the reception desk, spoke to the receptionist, wrote on the visitor log, walked through the reception area doors, and began heading down the hall towards the residents' rooms.On June 23, 2026, at 11:16 AM, V5 (Licensed Practical Nurse) said sometime in the afternoon on June 10, 2026, she saw V7 (R1's visitor), a man she did not recognize, walking down the hall towards R1's room. V5 said she kept an eye on him and saw him go into R1's room and wondered if he went into the wrong room. V5 said she realized he wasn't coming out of the room and her gut told her to go and check on R1. V5 said R1's room door was partially closed, and the curtain was pulled halfway closed so you could not see R1 from the hallway. V5 said she opened the room door and pulled the curtain back and saw V7 standing at R1's bedside with his back to the door. V5 thought this was odd behavior so she stood and watched him for a few minutes. V5 said V7 said Hi, do you remember me? to R1, which creeped her out. V5 said there was loud talking out in the hallway, and V7 turned to look, and this was when he saw V5 was in the room. V7 walked to other side of R1's bed and was now facing the door. V5 said she left R1's room and headed directly to V4 (Receptionist) and asked her who was V7. V4 said she had never seen him before. V5 asked V4 to check the sign in sheet. V5 said V4 checked the sign in sheet and there was an identifiable signature. V5 said she asked V4 to call social service and ask them if they can take a look and see if they can identify this man. V6 (Social Services Assistant) did not know who this person was and was only able to get his name and relationship to R1. V7 said his name was [first name], and he was a family member. V6 said that it was weird because the curtain was pulled when V6 went into the room. V6 said she would call the POA (Power of Attorney) to confirm who V7 was. V5 stayed at the reception area for a few seconds then walked over to V6's (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 - Actual harm Residents Affected - Few	office and asked if everything was ok. V6 informed her that she called the POA but was unable to leave a voice message. V5 went down to R1's room again, the door was open but the curtain by the door was completely closed. V5 said she pulled the curtain back and V7 was unaware of her presence. V7 he was standing on the right side of R1's bed facing the door, had his pants zipper down, his hand was by his penis, he was smiling as he adjusted the device in R1's mouth. V5 said she could see a white string coming from R1's mouth and she said, hey what's going on? V7 zipped up his pants and began yanking on the string in R1's mouth to remove the object he had placed there. V5 said there was a mouth guard in R1's mouth to keep her mouth open. V7 pulled three times on the string real hard and couldn't get the device to come out of R1's mouth. V7 put his hand on R1's forehead, pushed her head into the mattress as he yanked on the string attached to item that was in her mouth and ran into the bathroom. V5 said she stepped out of the room yelling for help, and a second later V7 came out of bathroom, and pushed her out of the way. V5 said she kept yelling for help and for someone to stop him as he headed down hallway. V5 said she later identified V7 to the police. On June 23, 2026, at 1:28 PM, V5 (Licensed Practical Nurse) said R1 never wears mouth guards.R1's progress note dated June 10, 2026, shows she was admitted to the hospital for possible assault.R1's progress note dated 06/11/2026 shows family proceeded to have a rape kit completed, which included the oral and upper portion of the rape kit.On June 23, 2026, at 10:37 AM, V4 (Receptionist) said she has worked at the facility for 4 years, all visitors check in and out at the front desk and sign the visitor log. V4 said all residents' profiles are checked for new visitors to screen for restrictions. V4 said if someone new visits a resident who is vulnerable the receptionist calls the nurse and asks if the resident is able to receive that visitor safely. On June 10th, V4 said she briefly greeted the man that visited R1 (V7). V4 said she is required to ask all visitors who they're seeing at the facility, but she couldn't recall if she asked V7 who he was here to see or what his response was. V4 was unable to recall her communication with him. V4 said there were two people coming into the building at the same time when V7 entered the building and she was speaking with both of them so she couldn't recall the exact communication. V4 confirmed the illegible signature on the sign in sheet dated June 10, 2026, with missing information of what room number was being visited and the time in and out was V7's writing. V4 said she was not familiar with V7. On June 24, 2026, at 3:43 PM, V6 (Social Services Assistant) said on June 10th she didn't know who V7 (Visitor) was and called the family for confirmation that this person was ok to be at the facility visiting R1 since R1 was not able to give consent. V6 said she was unable to reach the V8 (POA/Power of Attorney) at that time. V6 said residents who can't give consent would need to have a visitor confirmed with the family listed in their profile. V6 said on June 10th she told V5 to just keep an eye on the situation while she contacts R1's family. V6 said she was not aware V7 (Visitor) had not signed in when he entered the facility. V6 said she would have talked to the family first before having the visitor sign the book and allowing him to enter R1's room. On June 23, 2026, at 1:59 PM, V8 said V7 is a family member. V8 said she is concerned about what happened to R1 on June 10th at the facility during V7's visit. V8 said the nurse at the hospital told her a nurse at the nursing home walked in on V7 with his pants down, and a curtain closed while in R1's presence after V7 illegibly wrote his name in the guest book and a staff member noticed he seemed suspicious. On June 23, 2026, at 2:29 PM, V8 said she is concerned about the incident that occurred at the facility. V8 said although V7 has been arrested and has received three aggravated battery charges. V8 said the very nature of what V7 did was sexual assault, and V7 went to the facility for the sole purpose to do what he did. V8 said R1 can't speak but she can speak for R1. V8 said she plans to have sexual assault charges added to the aggravated battery charges for V7. V8 said she had never been asked to identify who can visit R1 and who cannot, prior to June 10th. V8 said she is unaware of V7 ever visiting R1 while at this facility. V8 said she knows V7 made an attempt to conceal his identity on June 10th when he came into the facility because he scribbled his name down on the visitor log. V8 expressed that what happened to R1 was very upsetting.The police report for R1 dated June 10, 2026 shows police were sent to the facility regarding a unknown male visitor that put (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	an unknown object inside a female patients mouth and then fled the facility; staff handed the officer a plastic bag with a black object in it that was attached to a white string and it was obtained as evidence; V5 reported to the officer when she walked in on V7 while he was in the room with the female patient (R1) the curtain was pulled closed and when she opened it, she saw V7 with his pants unzipped, his hand near his penis, a black object in the female patient's mouth and a white string hanging from it; the staff reported when she saw V7 he became startled, yanked extremely hard on the rope three times (same motion as trying to start a lawnmower) to try and remove the object but was unable to; V7 then had to grab the female patient by her forehead and hold her forehead down and then was able to yank the object out of her mouth. The reporting officer described the black object placed into evidence as a garage plug and rope from V7s garage, and a spacer to keep a mouth open.On June 24, 2026, at 4:16 PM, When asked how might R1 have reasonably felt about V7's behavior of putting a guard in R1's mouth and pulling it out aggressively, V2 (Director of Nursing) responded R1 didn't feel good about it. When asked how might R1 have been affected or reasonably felt if R1 had been sexually assaulted, V3 (Assistant Director of Nursing) said it's reasonable that R1 may have felt violated, shamed or afraid. On June 23, 2026, at 1:30 PM, V1 (Administrator) said visitors check in at the front desk, notify the receptionist who they are visiting and their room number, the receptionist will check to see if the resident has any restricted visitors, and the visitor signs in on the sign in sheet on the clip board at the reception desk. V1 said if a visitor is exhibiting suspicious behavior, the staff that observes the suspicious behavior needs to alert other staff to assist. V1 said if a staff observes a visitor exhibiting suspicious behavior the resident should not be left alone with the visitor. V1 said if the visitor fails to document on the visitor log who they're visiting the receptionist should fill that information in, and this information should be confirmed before the visitor is allowed past the doors at the receptionist area that leads to the resident's room. V1 said if the visitor has already entered the resident area and the receptionist notices that the visitor didn't document who they were visiting at the facility nor does the receptionist know who the visitor is there to see, the receptionist should notify management or nursing staff and have the visitor removed from the resident's room.The facility provided their policy titled, Abuse Prevention Program Facility Policy and Procedures with a revision date of January 4, 2019, showed, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation. irrespective of any mental or physical condition, cause physical harm. It includes sexual abuse, physical abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately. The facility final investigation showed, Based on a thorough investigation, there is no credible evidence that abuse occurred.

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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 observations, interviews, and record reviews, the facility failed to submit an accurate and complete abuse investigation report to the state agency.This failure applies to 1 of 3 residents (R1) reviewed for abuse.The findings include:R1's electronic medical records show she is a [AGE] year-old female with diagnoses and conditions including early onset Alzheimer's disease, anxiety disorder and impaired communication who was admitted to the facility on [DATE].On June 23, 2026, at 11:00 AM, R1 was lying in her bed in her room unable to speak, with her upper and lower extremities contracted and clinching her teeth in response when spoken to. R1's eyes widened in response to being spoken to and had an anxious expression on her face while observing the surveyor walking near or around her bed. On June 23, 2026, at 11:16 AM, V5 (Licensed Practical Nurse) said sometime in the afternoon on June 10, 2026, she saw V7 (R1's visitor), a man she did not recognize, walking down the hall towards R1's room. V5 said she kept an eye on him and saw him go into R1's room and wondered if he went into the wrong room. V5 said she realized he wasn't coming out of the room and her gut told her to go and check on R1. V5 asked V4 (receptionist) and V6 (social services) and no one could identify this visitor. V5 said V7 kept closing the room door most of the way, and/or pulling the privacy curtain so R1 was not visible from the hallway. V6 was calling V8 to see if she could identify V7. V5 went down to R1's room again, the door was open but the curtain by the door was completely closed. V5 said she pulled the curtain back and V7 was unaware of her presence. V5 said V7 was standing on the right side of R1's bed facing the door, had his pants zipper down, his hand was by his penis, he was smiling as he adjusted the device in R1's mouth. V5 said she could see a white string coming from R1's mouth and she said, hey what's going on? V7 zipped up his pants and began yanking on the string in R1's mouth to remove the object he had placed there. V5 said there was a mouth guard in R1's mouth to keep her mouth open. V7 pulled three times on the string real hard and couldn't get the device to come out of R1's mouth. V7 put his hand on R1's forehead, pushed her head into the mattress as he yanked on the string attached to item that was in her mouth and ran into the bathroom. V5 said she stepped out of the room yelling for help, and a second later V7 came out of bathroom, and pushed her out of the way. V5 said she kept yelling for help and for someone to stop him as he headed down hallway. V5 said she later identified V7 to the police.R1's progress note dated June 10, 2026, shows she was admitted to the hospital for possible assault.On June 24, 2026, at 11:33 AM, V15 (Insurance Care Manager) said she saw R1's emergency room doctors' notes for the incident that occurred June 10th that stated the nursing home suspected sexual abuse.R1's progress note dated June 11, 2026, shows family proceeded to have a rape kit completed, which included the oral and upper portion of the rape kit.On June 23, 2026, at 2:29 PM, regarding R1's incident at the facility on June 10th, V8 (Power of Attorney/Family Member) said she did have a rape kit done for R1 and felt it was V7's full 100% intent to sexually assault R1.The police report for R1 dated June 10, 2026, shows police were called to the facility for a staff member (V5) walking in on a male visitor (V7) in the room of a female resident (R1) and saw V7 with his pants unzipped, his hand near his penis, a black object in R1's mouth with a white string hanging from it and V7 forcefully removing the object from R1's mouth.On June 24, 2026, at 2:09 PM, V2 (Director of Nursing) and V3 (Assistant Director of Nursing) said V2 is the designated abuse coordinator when V1 (Administrator) is unavailable. V2 said she submitted the final abuse investigation report for R1 to the state agency and all pertinent information to an abuse allegation should be included in the investigation report provided to the state agency. V2 said she was advised not to include the information regarding V7's pants zipper being down while at R1's bedside in the report provided to the state agency. When asked if police reports are used in abuse investigations, V2 said she's never had to request a police report for a reportable and V16 (Activities Director) attempted to request the police report but had not been able to obtain it.The facility's final abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation report dated June 16, 2026, sent to the state agency shows on June 10, V5 (Licensed Practical Nurse) reported an allegation of V7 (Visitor/Family Member) possibly being inappropriate with R1 and did not include information regarding V7 standing at R1's bedside with his pants unzipped and his hand near his penis while putting something in R1's mouth. The report also did not include information regarding R1's family requesting a rape kit nor R1 being admitted to the hospital for possible assault. The facility's final investigation showed, Based on the thorough investigation, there is no credible evidence that abuse occurred.The facility's Abuse Prevention Program Facility and Procedure with revision date of January 4, 2019, shows.Employees are required to report any incident, allegation or suspicion of abuse. immediately to Administrator. or designee in administrators absence. Final investigation report shall contain the following. Facts determined during the process of the investigation. If there is a police report, attach the police report.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide evidence to the state agency that an allegation of abuse was thoroughly investigated.This failure applies to 1 of 3 residents (R1) reviewed for abuse.The findings include: R1's electronic medical records show she is a [AGE] year-old female with diagnoses and conditions including early onset Alzheimer's disease, anxiety disorder and impaired communication who was admitted to the facility May 11, 2024.On June 23, 2026, at 11:00 AM, R1 was lying in her bed in her room unable to speak, with her upper and lower extremities contracted and clinching her teeth in response when spoken to. R1's eyes widened in response to being spoken to and had an anxious expression on her face while observing the surveyor walking near or around her bed.R1's current care plan-initiated May 13, 2024, shows she is totally dependent on staff for all activities of daily living, requires two staff to turn and reposition, is non-ambulatory, non-verbal.On June 23, 2026, at 2:29 PM, regarding R1's incident at the facility on June 10th, V8 (Power of Attorney) said although V7 has been arrested and received three aggravated battery charges, she said the very nature of what V7 did was sexual assault, V7 went to the facility for the sole purpose of what he did and V8 plans to have sexual assault charges added to V7's charges. V8 said she did have a rape kit done for R1.The facility's final abuse investigation report dated June 16, 2026 that was sent to the state agency shows on June 10, V5 (Licensed Practical Nurse) reported an allegation of V7 possibly being inappropriate with R1 and did not include information regarding V7 standing at R1's bedside with his pants unzipped and his hand near his penis while putting something in R1's mouth. The report also did not include information regarding R1's family requesting a rape kit nor R1 being admitted to the hospital for possible assault. The report shows the facility concluded that based on their investigation there is no credible evidence that abuse occurred.R1's progress note dated June 10, 2026, shows she was admitted to the hospital for possible assault.On June 24, 2026, at 11:33 AM, V15 (Insurance Care Manager) said she saw R1's emergency room doctors' notes for the incident that occurred June 10th that stated the nursing home suspected sexual abuse.On June 23, 2026, at 11:16 AM, V5 (Licensed Practical Nurse) said on June 10, 2026, she observed V7 (Visitor) standing on the right side of R1's bed facing the door. He was smiling while adjusting the device in R1's mouth, with his pants zipper down, and his hand near his penis before he realized she was in the room. V5 asked V7 what he was doing, but he would not answer and ran into the bathroom. The police report for R1 dated June 10, 2026 shows police were sent to the facility regarding a male that put an unknown object inside a female patients mouth and then fled the facility; the staff at the facility reported to the officer when she walked in on V7 (Visitor/Family Member) while in the room with the female patient and saw V7 with his pants unzipped, his hand near his penis, and a black object in the female patient's mouth with a white string hanging from it; V7 held down R1's head while aggressively pulling the object out of R1's mouth; and V7 was arrested for aggravated battery of a senior citizen and a person with physical disability.On June 24, 2026, at 2:09 PM, V2 (Director of Nursing) and V3 (Assistant Director of Nursing) said V2 is the designated abuse coordinator when V1 (Administrator) is unavailable. V2 said she submitted the final abuse investigation report for R1 to the state agency and all pertinent information to an abuse allegation should be included in the investigation report provided to the state agency. V2 said she was advised not to include the information regarding V7's pants zipper being down while at R1's bedside in the report provided to the state agency. V2 said there is no way to prove abuse occurred for R1 on June 10th. When asked if police reports are used in abuse investigations, V2 said she's never had to request a police report for a reportable and V16 (Activities Director) attempted to request the police report but had not been able to obtain it. V2 said the facility did investigate the abuse allegation for R1 on June 10th for any form of abuse that may have occurred. V2 said she doesn't believe the way V7 pressed down R1's forehead and pulled out the guard is considered assault. The facility provided (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	final investigation report showed, Based on the thorough investigation, there is no credible evidence that abuse occurred.The facility's Abuse Prevention Program Facility and Procedure with revision date of January 4, 2019, shows.Employees are required to report any incident, allegation or suspicion of abuse. immediately to Administrator. or designee in administrators absence. Final investigation report shall contain the following. Facts determined during the process of the investigation. If there is a police report, attach the police report.