

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145694	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Renwick Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Hennepin Drive 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide proper infection control practices for 55 residents (R2 - R56) after a positive COVID-19 exposure and failed to follow their COVID-19 policy.</p> <p>Findings include:</p> <p>On 7/23/24 at 10:45 AM there was no sign on the facility's front entry door showing that the facility was currently in an outbreak status for positive COVID-19.</p> <p>On 7/23/24 at 2:05pm R1 stated that she had not been tested for COVID-19 after she was informed that the facility had positive cases. On 7/23/24 at 2:15 pm R2 stated that she had not been recently tested for COVID-19. On 7/23/24 at 2:22pm R3 stated that she had not been tested for COVID-19 after she had been notified that there were positive cases in the facility.</p> <p>On 7/24/24 at 9:10 AM, V12 (CNA/certified nursing assistant) stated that she came to work on 7/2/2024 at 6:00 PM. V12 stated that from about 6:30pm - 10pm she was helping the other CNAs do work, getting water for the residents, doing laundry, and running around the building doing other things. V12 stated that she had sat in the common area for a while where there were residents in that area. V12 stated that she was around other staff and residents but did not remember who. V12 stated that during this time she kept running to the bathroom. V12 stated around 10pm she reported to V11 (Night Shift Nursing Supervisor) that she was feeling sick and V11 told her to go to the break room where she stayed until she went home around 2 am. V12 stated that she tested herself that morning at home and she was positive for COVID-19. V12 stated that the facility only tested her one time for COVID-19 and that was on 7/12/24 the day she returned to work.</p> <p>On 7/24/24 at 9:27 AM V11 (Night Shift Nursing Supervisor) stated that on 7/2/24, V12 told her she was not feeling well around 8:30 pm. V11 stated that V12 was on the floor helping other CNAs and in the common area for a couple of hours, where she is sure there were residents but could not recall which ones. V11 stated that V12 was also around other staff including herself. V11 stated that on the morning of 7/3/24, she had told V4 (Infection Preventionist), that V12 had been around some of the residents in the common area and around the staff. V11 stated that since she was exposed on 7/2/24 she has only been tested on e time, a few days after being exposed.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/23/24 at 12:42 PM, V4 (Infection Preventionist Nurse) stated that the facility came out of COVID-19 outbreak status the previous day, 7/22/24. V4 stated that the facility had been in an outbreak status since 7/3/24 when V12 CNA (Certified Nurse's Assistant) tested positive and then on 7/10/24 a second staff V10 (Minimum Data Set Coordinator) tested positive. On 7/24/24 at 10:15 AM, V4 stated that she had mistakenly took the sign down on 7/23/24 even though the facility was still in outbreak status through 7/24/24. On 7/23/24 at 12:42 PM, V4 stated that on 7/2/24, V4 came to work for her 6 pm - 6am shift but went home early on 7/3/24 because she was sick. V4 stated that she was informed that V12 was sitting in a common area where some residents were also sitting. V4 stated later that morning she had received a text picture from V11 (Night Shift Nursing Supervisor) showing that V12 had tested positive for COVID-19. On 7/24/23 at 10:54 AM, V4 stated that she did not test any residents as she should have that may have been exposed to V4 on 7/2/24 - 7/3/24. V4 stated that she only tested some residents on 7/10/24 after the facility had their 2nd positive COVID-19 case. On 7/24/24 at 11:50 AM, V4 stated she did not know what residents were in the common area when V12 was sitting there, and it would have made the most sense if she had tested all of the residents from that area (R2-R56) but she did not. V4 stated she contacted the Will County Health department 3 days after the 2nd positive case, (7/13/24) and was instructed that she should have tested everyone. On 7/24/24 at 10:15 AM, V4 stated that she tested some staff but did not start documenting the testing until 7/15/24. At 10:52 AM V4 said that there were too many people for her to track and she did not follow up on the tracking and documentation because she trusted everyone would come to her as they were told.</p> <p>On 7/24/24 at 12:46 pm, V2 DON (Director of Nursing) stated to her knowledge V12 was in the common area around unknown residents on 7/3/24. V2 stated that it is her expectations that V4 should test and track all persons that came in contact with V12. V2 stated that R2 - R56 should have been tested . V2 stated that V4 should have a line list for both staff and residents tracking from the 1st day exposed (day 0) and testing on 7/4/24 (day 1), 7/6/24 (day 2), and 7/8/24 (day 3). V2 stated that R2 - R56 were not tested on those days at all. V2 stated that she has no documentation, nor any knowledge of any staff being tested after being in contact with V12 on 7/2/24 - 7/3/24. V2 stated that any staff that had been in close contact with V12 should have been tested 3 times and that it is the responsibility of the Infection Preventionist Nurse to have staff tested and if they do not, they should be removed from the schedule. At 2:12 PM, V2 stated that R2 -R56 should have been put on at least EBP (enhanced barrier precautions) once they were possibly exposed, and they should have stayed on the precautions for the duration of the testing time. V2 stated that none of the residents were put on any type of precautions during this time. V4 stated that it is her expectation that V4 put R2 - R56 on those precautions. V2 stated that it is the facility's policy to test the residents and staff after a positive exposure or possible exposure and the testing is recommended on the 1st 3rd and 5th day. V2 stated the days of testing should have been 7/4/2024, 7/6/2024, and 7/8/2024. V2 stated that the policy shows that if contact tracing fails then broad-based approach should be used. V2 stated that means that V4 should have tested all of the residents in that area, (R2 - R56). V2 stated that the facility's policy shows that the residents should be put on transmission-based precautions. V2 stated, while looking at the facility's staff tracking form, that it was not sufficient testing. V2 stated that all staff that came in contact with V12 on 7/3/24 - 7/4/24, should have been tested on [DATE], 7/6/2024 and 7/8/2024.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/23/24 at 1:42 PM, V5 (Acting Administrator from 4/18/24 - 7/22/24) stated that the facility was in a COVID-19 outbreak from 7/3/24 - 7/22/24. On 7/24/24 at 3:07 PM, V5 stated that R2 - R56 should have been tested for COVID-19 immediately after V12 tested positive on 7/3/24. V5 stated while looking at the facility's COVID policy, that the policy shows to test anyone that may have been exposed to someone that is positive for COVID-19, to be tested on day 1, then again 48 hours, (if negative), and again after 48 hours for a total of 3 tests. V5 stated while looking at the facility's policy, that R2-R56 should have been put on transmission-based precautions until after 7 days from the day of exposure, and they were not. V5 stated that the staff should have been tested the same as the residents and V5 is responsible to do the testing and the tracking.</p> <p>A review of V12's Attendance Application showed that V12 worked on 7/2/24 from 6:24 pm to 2:32 am. A review of the facility's 7/2/24 daily staffing sheets showed that V12 came to work at 6pm and was assigned to the same units as V11 & V14 (Nurses), and V20, V16, V19, & V2 (CNAs).</p> <p>The facility was unable to provide any documentation of COVID-19 testing/tracking for any staff and for R2 - R56 for 7/4/23, 7/6/24 or 7/8/24. A review of the facility's 7/10/2024 COVID-19 testing/tracking form showed testing was done or offered to only 17 of the possible 55 residents exposed, (R5 - R13 & R31 - R36). The documentation showed that they received their 1st test on 7/10/24, 6 days after being exposed. There was no documentation for the other 39 residents that were possibly exposed, (R1 - R4, R14 - R30, & R38 - R56).</p> <p>A review of the facility's COVID-19 policy with a review date of 05/08/2024 showed the incubation period for COVID-19 is from the time of exposure until signs and symptoms appear and is estimated at 4 - 7 days but can range from 1 to 14 days. The policy shows that to establish a process to identify and manage individuals with suspected or confirmed COVID-19, post visual alerts at the entrance and in strategic places. Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others. Perform testing for all residents and healthcare professionals identified as close contacts or on the affected units if using a broad-based approach regardless of vaccination status. Testing is recommended immediately but not earlier than 24 hours after the exposure, and if negative again 48 hours after the first negative test, and if negative again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. The policy shows under Responding to a newly identified SARS-CoV-2 infected healthcare professional or resident, when performing an outbreak response to a known case, facilities should always defer to recommendations of the jurisdiction's public health authority. A single new case of SARS-CoV-2 infection in a health care professional or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or broad-based approach; however, a broad based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or contact tracing fails to halt transmission. Performing testing for all residents and healthcare professionals identified as close contact or on the affected units if using a broad-based approach, regardless of vaccination status, testing is recommended immediately but not earlier than 24 hours after the exposure, and if negative again 48 hours after the first negative test, and if negative again 48 hours after the second negative test period. This will typically be at day one where day of exposure is day zero, day three, and day five. Empiric use of transmission-based precautions for residents and work restrictions for health care professionals are not generally necessary unless residents meet their criteria described in Section 2 .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's Isolation - Categories for Transmission-based Precautions policy dated 01/20/2024 showed transmission-based precautions are the 2nd tier of basic infection control and are to be used in addition to standard precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Transmission based precautions will be used whenever measures more stringent than standard precautions are needed to prevent the spread of infection.</p> <p>A review of the state agencies Long-Term Care Facilities Guidance COVID-19 showed that testing is required for the following: Symptomatic residents or HCP (healthcare professionals), even those with mild symptoms of COVID-19, should receive a viral test for SARS-CoV-2 as soon as possible. Implement recommended infection prevention and control (IPC) practices when caring for a resident with suspected or confirmed SARS-CoV-2 infection. Asymptomatic residents and HCP with a close contact or higher-risk exposure with someone with SARS-CoV-2 infection are recommend to have a series of three viral tests for SARS-CoV-2 infection unless they have recovered from COVID-19 in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days . Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. The guidelines show under Outbreak testing, Facilities can choose to investigate an outbreak using contact tracing or a broad-based approach. A broad-based approach includes the unit, floor, or other specific area of the facility where the positive COVID-19 case was identified (this could be where the resident resides or where the HCP worked). If a facility is unable to conduct contact tracing or contacts cannot be identified, the facility should follow a broad-based approach. When using the broad-based approach, a facility should continue to test every 3-7 days until there are no more positive cases identified for 14 days. If additional cases are identified after testing a unit, floor, or specific area of the facility, the facility may expand testing to facility-wide testing if testing and implementation of infection control measures have failed to halt transmission.</p>		