

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 10/24/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>36567</p> <p>Based on observations and interview the facility failed to maintain resident room temperature at a comfortable setting to provide homelike environment.</p> <p>This applies to 6 of 6 residents (R17, R30, R43, R86, R245, R346) reviewed for environment in the sample of 19.</p> <p>The findings include:</p> <p>On October 21, 2024, at 10:33 AM, R346 stated I do not have heating or cooling in my room. It gets to 58 degrees in my room at nighttime. I bought a thermometer for my room. My family bought me extra blankets so I can stay warm at night. I put some blankets by the windows to block to cold air from coming in the room. They put this [heating and cooling] unit in the room since I came here but it doesn't work. Administration just keeps saying they are working on it. They tried to move my room, but I asked if it had heat, and it did not. R346's thermometer that was on nightstand showed 66 degrees Fahrenheit.</p> <p>On October 23, 2024, at 8:54 AM, R346's room temperature was checked with facility digital thermometer by V11 (Maintenance Director) and showed 72.4 degrees Fahrenheit. Facility digital thermometer was set right next to R346's thermometer which showed 70 degrees Fahrenheit. This showed a variance of 2.4 degrees Fahrenheit between the two thermometers. This would have had facility thermometer read at 68.4 degrees Fahrenheit when R346's thermometer showed 66 degrees Fahrenheit as observed earlier.</p> <p>On October 21, 2024, at 11:25 AM, R86 stated that he is not sure is his heater unit works as no heat blows out from it. R86 stated I had my blanket and sweater on a few days earlier when it was cold.</p> <p>On October 21, 2024, at 11:30 AM, R17 stated that the new heater unit was just put in and that everyone had to put on a lot of clothes and blankets as the other one (unit) did not work at all.</p> <p>On October 21, 2024, at 12:10 PM, R245 stated My room unit doesn't work, I don't when they are working on it. If the door is open, then it doesn't get too cold in here. R245's room unit had multiple hoses that were disconnected and lying on the floor with the pipe visible and nothing connected to it.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 22, 2024, at 8:20 AM, R30 was seen in bed with multiple blankets and stated It's freezing in the night. That's why I have three blankets.</p> <p>On October 22, 2024, at 2:00 PM, during Resident Council Meeting, R43 stated that the 100 hallways still do not have any heating. R43 stated A couple nights ago when it [temperature] was in the 30's, it was pretty cold. It has been going on and on. When are they going to fix it?</p> <p>On October 21, 2024, at 8:22 AM, V11 stated that the temperatures should not be below 70 degrees Fahrenheit.</p> <p>On October 21, 2024, at 3:05 PM, V1 (Administrator) stated that when the facility identified issues with the air conditioning over the summer, the facility hired an outside service who stripped out all the electrical system as a leak was identified. V1 stated that the facility learnt later that they never should have done that as it had to be put back in again and the facility hired another contractor to fix that. V1 stated that the facility begun the process of installing new heating/cooling units in each room and have almost completed the project except in the 100 unit. V1 was not aware that some of the rooms that had been completed were not connected to the cooling/heating unit.</p> <p>On October 21, 2024 at 3:35 PM, V14 (Vice President of Operations) stated that all rooms except the left side of 100 hallway should have heating and cooling by October 22, 2024. V14 stated that the facility went back to the original system after all the repairs of the tear down's done earlier to amend this problem. V14 stated that the 100 unit was delayed as the original heat pumps were damaged when taken out and new one's have been ordered which should arrive in the next two weeks. V14 stated that the facility has made arrangements with a company for providing heating units for these rooms if the need arises with weather changes and fluctuating room temperatures until these heat pumps are installed.</p> <p>Facility Policy titled Loss of Heat during cold weather policy (effective February 2014, updated January 2020) included as follows:</p> <p>Policy: To establish guidelines to maintain a safe and comfortable environment in the event of the loss of heat.</p>

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303</p> <p>Based on interview and record review, the facility failed to follow therapy's recommendations for safe transfer of a resident.</p> <p>This failure resulted in R345 sustaining a laceration on R345's left leg requiring six sutures due to an improper transfer.</p> <p>This applies to 1 of 3 residents (R345) reviewed for resident injury in the sample of 19.</p> <p>The findings include:</p> <p>The EMR (Electronic Medical Record) showed R345 was admitted to the facility on [DATE], with multiple diagnoses including dementia, peripheral vascular disease, heart failure, and lymphoid leukemia.</p> <p>R345's MDS (Minimum Data Set) dated August 9, 2024, showed R345 had severe cognitive impairment. The MDS continued to show R345 required substantial assistance from facility staff for bed to chair transfers.</p> <p>R345's ADL (Activity of Daily Living) care plan dated June 6, 2024, showed, The resident has an ADL self-care performance deficit needs and participation may vary related to cognitive deficits, impaired speech, weakness. The care plan continued to show multiple interventions dated June 6, 2024, including Mechanical lift for transfers.</p> <p>On October 22, 2024, at 2:16 PM, V15 (CNA/Certified Nursing Assistant) said on September 28, 2024, V15 transferred R345 by herself using a gait belt. V15 continued to say R345 scraped his left leg into the wheelchair and then she noticed some bleeding from his leg and alerted the nurse. V15 said R345 was supposed to be transferred with a mechanical sit-to-stand lift with two facility staff members. V15 continued to say R345 had very fragile skin and V25 needed to be very careful when transferring R345. V15 said the transfer was a part of routine care and there was not an emergency.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Facility Incident Report Form completed by V2 (DON/Director of Nursing) on September 28, 2024, showed, Description of Occurrence: Resident who is alert times one, was observed with bleeding from his left lower leg during transfer from bed to his wheelchair. Left lower leg was cleansed and dressing applied, and resident was assessed for pain, no pain observed or reported. Physician was called and orders were given to send resident to hospital for evaluation and treatment. Family notified of incident and new orders. Resident was sent out to hospital. Resident has returned back from hospital with six sutures to left lower leg, pain assessment completed, and pain being managed appropriately per orders. Investigation in process. Occurrence Resolution: During transfer with staff aide on September 28, 2024, [R345]'s left lower extremity came in contact with the top of his leg rest on wheelchair resulting in skin alteration to left lower extremity, resident is taking anticoagulant, and orders were received by primary care clinician to send to hospital for evaluation and treatment. [R345] has returned back to facility after receiving treatment at hospital for laceration to left lower extremity. Six sutures were applied to left lower extremity that will be removed in 10 days in house by wound care nurse, extremity is assessed every shift for change in condition. Primary care clinician aware of new orders and family also made aware. Pain assessed and managed appropriately per orders. Cushion has been applied to top part of leg rest. Therapy to screen for transfers. Plan of care updated to reflect changes.</p> <p>On October 22, 2024, at 2:57 PM, V16 (Director of Rehab) said R345 was discharged from Physical Therapy and Occupational Therapy on August 9, 2024. V16 said upon R345's discharge from therapy, therapy's recommendations were for facility staff to utilize a mechanical sit to stand lift. V16 continued to say two facility staff members are required when using a mechanical sit to stand lift. V16 said facility staff are to follow the special instructions shown in the resident's EMR. V16 said R345's EMR showed R345 was a mechanical sit to stand transfer. V16 continued to say it is the expectation facility staff follow therapy's recommendations for a safe transfer.</p> <p>On October 22, 2024, at 3:32 PM, V17 (Nurse Practitioner) said it is the expectation that facility staff follow therapy's recommendations for a resident's safe transfer. V17 continued to say facility staff should have transferred R345 per therapy's recommendations to prevent R345 from getting injured.</p> <p>On October 23, 2024, at 3:40 PM, V2 said facility staff should be following the special instructions in the EMR for how a resident should be transferred. V2 continued to say V15 should have transferred R345 with a second facility staff member using a mechanical sit to stand lift.</p> <p>R345's hospital records dated September 28, 2024, showed R345 had a leg laceration requiring sutures.</p> <p>The facility's policy titled Safe Lifting and Movement of Residents dated August 2008, showed Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care this facility uses mechanical lifting devices for the lifting and movement of residents. Policy Interpretation and Implementation: 1. Mechanical lifting devices shall be used for any resident needing a two person assist. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted . 7. The transferring needs of residents shall be assessed on an ongoing basis. Resident transferring and lifting needs shall be documented in the care plan .</p>		