

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 01/16/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<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** 48526</p> <p>Based on interview and record review, the facility failed to ensure a resident was positioned safely in bed for cares. This failure resulted in R1 falling and sustaining fractures of her right femur and right tibia, and a right knee dislocation.</p> <p>This applies to 1 of 3 residents (R1) reviewed for safety/falls.</p> <p>The findings include:</p> <p>R1's Face Sheet showed she was admitted to the facility on [DATE], and her diagnoses include hemiplegia and hemiparesis following a cerebral infarction (affecting right dominant side), rheumatoid arthritis, polyneuropathy, obesity, and chronic pain.</p> <p>The facility's 1/3/2025 Final Report for R1's 12/31/24 fall incident showed Occurrence Resolution The root cause was determined to be the resident's lower extremities sliding off the bed during turning, changing, and repositioning as part of routine care During the incident, the resident's lower extremities became too close to the edge of the bed and slid off .</p> <p>R1's Progress Notes dated 12/31/24 at 12:45 PM showed . Nurse alerted by nursing staff that resident had fallen out of bed. Nurse observed resident lying on her back on the floor. Resident stated she was in the bed and was turned on her right side to get her brief changed. Resident stated she fell out of bed while being changed. Resident stated she had pain in her right knee. Patient transferred to bed via facility protocol . New orders for resident to be sent to ER (ER/emergency room) for evaluation and treatment given. Ambulance arrived at the facility for transport resident to (Hospital) at approximately 12:00 PM.</p> <p>The Findings section of R1's 12/31/24 diagnostic imaging report from the local hospital showed 1. Posterior dislocation of the right tibial prosthesis of the knee, and 2. Proximal right tibial fracture.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/14/25 at 1:52 PM V11 CNA (Certified Nursing Assistant) stated she was the CNA that was taking care of R1 when she fell . V11 stated R1 had been sitting up in the bed when she entered the room and she put the bed flat for cares. V11 stated she directed R1 to turn onto her right side (R1's affected side), facing the door. V11 stated she gave peri-care to R1 while she was lying on her right side and V11 herself was on the opposite side of the bed (the left side of R1's bed). V11 stated R1 was closer to the edge of the bed on the right side, not closer to her. V11 stated she reached over to the nightstand to get some cream and she heard R1 say something, but she couldn't understand her. V11 stated she finally understood R1 to say, I'm slipping and she turned around. V11 stated she saw R1's hips moving, and she tried to grab R1's hips and she could not hold her and R1 went to the floor. V11 stated R1 had grabbed the halo bar. V11 stated she guessed R1's leg slipped over her other leg, and she began to slide to the floor. V11 stated that she had taken care of R1 before and had other staff members assist with changing her, but no one was available to assist that day.</p> <p>On 01/14/25 at 2:22 PM, V13 (Wound Care Nurse) stated she was in the hallway when she heard R1 yell out. V13 stated she saw R1 holding onto the bed rail and her knees were on the floor. V13 stated she went and got R1's nurse and the mechanical lift to get R1 off the floor. V13 stated there was only one CNA in the room assisting R1.</p> <p>On 01/14/25 at 2:10 PM, V12 (Licensed Practical Nurse) stated she was the nurse taking care of R1 on the day she fell out of the bed. V12 stated she was at the nursing station and was told her R1 was on the floor. V12 stated she assessed R1 and after she was back in bed, R1 complained of knee pain and R1 was sent to the hospital.</p> <p>R1's 12/31/24 progress note from 6:35 PM showed Nurse on duty contacted (local hospital). Resident is being transferred out to another hospital. (Local hospital) does not have an ortho doctor on call. Waiting to find out which hospital resident will be transferred to.</p> <p>R1's 1/1/2025 progress note from the second hospital listed musculoskeletal issues of right prosthetic knee dislocation, right periprosthetic femur fracture, and right periprosthetic tibia fracture.</p> <p>R1's CNA Point of Care (POC) charting for Roll Left and Right two-person assist regarding the ability to roll from lying on back to left and right side and return to lying on back on the bed from 12/25/24 until 12/31/24 was reviewed. R1's POC charting had 17 entries, with 16 entries as Dependent- Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.</p> <p>R1's weight summary showed R1's weight on 12/26/24 was 342 pounds.</p> <p>R1's MDS (MDS/Minimum Data Set) dated 10/25/24 showed R1 had upper and lower extremity impairments on one side of her body. The same MDS showed R1 used substantial to maximum assist with rolling side to side while in bed.</p> <p>R1's 7/10/24 Nursing Rehab Bed Mobility care plan showed a Focus for Resident to turn from left to right while in bed with assistance x(times)2 staff participation and the frequency. The Goal for the care plan showed Resident with a goal to be able to do one person assist for bed mobility. The date initiated for the goal was 7/10/24, and the target date is 1/31/2025.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>On 01/10/25 at 2:22 PM, V4 (MDS Coordinator) stated R1 should have had two people with turning and repositioning due to her size and her hemiplegia. V4 stated those two factors contribute to R1's lack of mobility. V4 stated R1 was documented as being dependent in POC, which means she should have two people for repositioning and toileting hygiene in bed.</p> <p>R1's second hospital Consult Initial Report dated 01/01/25 .Patient stated she 'kept telling them that she was too close to the edge.' Right upper extremity with mild wrist and finger contractures likely chronic from [cerebrovascular accident] with residual right sided deficits. Right leg is extremely rotated. Right knee is swollen and diffusely tender to palpitation. Patient underwent open reduction of the right prosthetic knee with application of a short leg splint .</p>		