STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145694	A. Building B. Wing	04/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renwick Nursing and Rehab	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)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the required physician documentation was included in the medical record to support a resident's transfer and discharge rights. This applies to 1 of 3 residents (R1) reviewed for transfer and discharge rights. The findings include: R1's Face Sheet showed he is [AGE] years old with diagnoses of schizophrenia and other specified disorders of the male genital organs, and he was admitted to the facility on [DATE]. R1's 4/18/25 Discharge Summary note from 9:17 AM showed R1 chose to leave the facility AMA (Against Medical Advice) the next day. On 4/23/25 at 12:49 PM, V1 (Administrator) emailed R1's completed Petition for Involuntary/Judicial Admission, and R1's completed Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents (IVD). The IVD form showed the reason for the proposed transfer or discharge is the safety of individuals in this facility is endangered R1's 4/17/2025 Petition for Involuntary/Judicial admission showed the facility is seeking involuntary and emergency inpatient admission by certificate. On 4/23/25 at 12:30 PM, V2 (Director of Nursing) stated he completed both R1's Petition for Involuntary/Judicial admission and R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents as he was instructed to by corporate personnel. On 4/24/25 at 1:20 PM, V2 clarified he was told by corporate staff to complete both forms. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 11:50 AM, V3 (Social Services Director) stated she has written up the Petitions for involuntary psychiatric admissions in the past when residents become a danger and if the physician is in agreement. V3 stated she has worked at the facility for eight years and remembers only about two IVDs being completed, and they are not done with Petitions for Involuntary/Judicial Admission. V3 stated for the Petition for Involuntary/Judicial admission form, boxes are checked that apply to the resident, and in the behaviors box, she would quote the resident if they wanted to harm themselves, include past psychiatric history, and would document facility attempts to re-direct the resident in an effort to show the need for immediate psychiatric care. V3 stated an IVD is typically handled by the Administrator, and she only becomes involved when the facility is looking for alternate placement, but that circumstance is infrequent. V3 stated usually I fill out the petition and hand it to the nurse when a resident is a danger to himself, and the physician feels the same way .you follow MD/medical doctor orders- you absolutely have to involve the MD. The behaviors box showed in the Petition showed State in detail the signs and symptoms of mental illness displayed by the Respondent. Include prior diagnosis, treatment and hospitalizations. Describe any threats, behavior, or pattern of behavior which supports your complaint. Include personal observations that lead to your belief the Respondent is subject to involuntary admission The behaviors box in R1's unsigned 4/17/25 Petition for Involuntary/Judicial admission showed Resident entered the facility after admitting from hospital escaped through resident's room window. R1's unsigned IVD form showed the date of the proposed transfer or discharge 4/17/2025 (although the form showed a copy was placed in R1's medical record on November 27, 2024). R1's IVD form showed .the reason for this proposed transfer or discharge is the safety of individuals in this facility is endangered, and where it asks if emergency transfer is, box is checked no. R1's hospital notes showed he arrived at the Emergency Department (ED) at 10:27 PM on 4/17/25 for Chief Complaint: Behavioral Health Evaluation. The ED Physician Report showed .The history was confirmed by the patient, who expressed a desire not to remain at the nursing home earlier but denied any thoughts of self-harm or harm to others. He denies hallucinations. He presents with a petition from nursing home which does not clearly identify immediate safety concerns. The Report showed R1 was in no acute distress and was cooperative and participatory with examination. R1's hospital Physician Report showed SUMMARY: XXX[AGE] year-old male presented from a nursing home after attempting to elope twice today. He was just placed there today .initial evaluation and short ED observation no emergent medical condition was identified. The patient did not appear acutely psychotic or manic, there was no immediate safety concern such as suicidal or homicidal risk. Is calm and cooperative without any concerns, he had no complaints. Petition was invalid. The patient also presented with involuntary discharge paperwork from nursing home, which was incorrectly completed, emergency discharge was marked as no. In the same paperwork, discharge destination is noted as the nursing home. The patient was evaluated, and no acute interventions were required. He was discharged back to the nursing home with no immediate concerns. On 4/24/25 at 11:20 AM, V9 (Licensed Practical Nurse [LPN] and MDS Coordinator) verified R1's 4/17/25 Nursing progress note from 11:38 PM was actually created 4/18/25 at 10:41 AM. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nursing progress note dated 4/17 showed R1 arrived around 8:00 PM and he was seen exiting the building at 8:15 PM and was returned at 8:20 PM. The note showed around 8:30 PM, R1 was no longer in his room, the window was partially open with the screen dislodged, 911 was called, and R1 placed under one-to-one supervision when he returned. The note showed The Director of Nursing initiated and completed the Involuntary Discharge (IVD) documentation at the facility. Fire and Rescue personnel subsequently transported the resident to [local] hospital with the IVD paperwork. The note lists the Police Department Incident number and that Dr. [Name] was notified of the incident, and the resident's mother [name] was also contacted . R1's April 2025 Physician Order Sheet (printed 4/23/25) does not include any Physician Orders to petition R1 out of the facility for an involuntary psychiatric admission, and the Orders do not include any involuntary discharge or other type of discharge orders. On 4/24/25 at 11:20 AM, V9 also verified R1's 4/18/25 admission Summary from 2:32 AM was also created on 4/18/25 at 10:11 AM. The Summary showed R1 displayed behaviors of agitation and/or anxiety. Resident has a past history of elopement or exit-seeking behaviors. On 4/24/25 at 11:40 AM, V9 verified no resident behaviors were documented by the CNAs (Certified Nursing Assistants) for all three entries included in R1's 4/17 and 4/18 Behavioral Monitoring task charting. All three values entered only showed resident is not available. V9 verified there were no Nurse Practitioner or MD progress notes regarding the need for R1 to be petitioned out or involuntarily discharged in R1's EMR (Electronic Medical Record). On 4/24/25 at 12:30 PM (six days after discharge), V8 (Medical Records) stated R1's EMR chart is complete and closed. V8 stated she there was no Physician order to petition R1 to the hospital or to discharge him and verified there were only three progress notes by facility staff. The facility's undated Involuntary Transfer and Discharge Process Key Elements policy showed II. Discharge when the facility is unable to meet the resident's needs .A. Emergency Transfer: Physical safety of resident, other residents, facility employees or visitors at the facility . person initiating the discharge should write 'Emergency' on the Notice of ITD form .Need physician to confirm that the transfer was necessary (need physician's order). Reasons or discharge must be clearly documented in resident's medical record .Facility must document the danger that the failure to transfer or discharge would pose . The policy section B. Non-Emergency Transfer: Medical Reason shows a 21-day notice is required.