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	06/23/2025

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 0600 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility failed to protect a resident's right to be free from mental abuse. This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 3. The findings include: R1's face-sheet showed R1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus, hypertension, benign prostatic hypertrophy, and depression. R1's 5/21/25 MDS (Minimum Data Set) showed he has moderate cognitive impairment. R8's 6/12/25 MDS showed he has severe cognitive impairment. R1's 6/8/25 progress note from 4:14 AM showed R1 had a verbal altercation with his roommate (R8). The note showed they were separated and R8 was moved to another room for the night. On 6/18/25 at 1:10 PM, V6 (Nursing Supervisor) stated she was informed by V5 LPN (Licensed Practical Nurse) that R8 alleged R1 pulled out a knife at R8. V6 stated she sent a message to V2 (DON-Director of Nursing). On 6/17/25 at 3:20 PM, V2 (DON) stated that on the early morning of 6/8/25 around 4:15 AM, he was notified that R8 had alleged R1 (his roommate) threatened him with a small pocketknife. V2 stated V5 had moved R8 to another room where R8 was more comfortable and felt safe. V2 stated nursing staff did a room check and did not find any knife in the room, and that R1 did not allow the staff to do a body check on him. R1 remained supervised in the single room. V2 stated R1's family was called and R1's two sisters arrived at the facility at about 10:00 AM. R1, and the DON had a meeting together. V2 stated when family spoke with R1, he took out a small knife from his sock, which was confiscated, and R1 was sent out to the hospital as ordered by his Physician. R1's 6/8/25 Late Entry progress note from 2:00 PM showed R1 was found in a state of agitation, holding a knife and making alarming remarks, stating that he has killed before and would do so again. Recognizing the immediate risk to safety, the knife was promptly removed. R1's 6/9/25 progress note from 9:37 AM showed R1 had been admitted to the hospital with altered mental status. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Abuse Prevention Policy defined abuse as .the willful infliction of intimidation . with resulting mental anguish . The policy further showed threats of harm is defined under verbal abuse, and mental abuse includes, but is not limited to humiliation, harassment, threats of punishment .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident at high risk for falls received adequate supervision and assistance to prevent accidents. This applies to 1 resident (R2) reviewed for accident hazards in a sample of 3. This failure resulted in R2 who was transferred via the sit to stand with the assist of one sustaining an injury to her left eyebrow from falling forward and hitting her head on the machine Findings include: On 6/18/25 at 11:30 AM, R2 stated, V8 (CNA-Certified Nursing Assistant) was transferring her from chair to bed using a sit to stand machine. As V8 (CNA) was moving R2 on the lift, R2 fell forward and hit her head on the machine. R2's left eyebrow was bleeding as she was on a blood thinner. R2 stated, the CNA did not have anyone to help her during the transfer. On 6/18/25 at 2:30 PM, R2's face-sheet showed, R2 was a 94 y/o (years old) female admitted to facility on 1/10/23 with diagnoses to include cerebral infarction, dementia, depression, hypertensive heart disease and protein-calorie malnutrition. R2's MDS (Minimum Data Set) dated 5/28/25 showed R2's Brief Interview of Mental Status (BIMS) as 12 indicating moderate cognitive impairment. R2's Care Plan dated 5/25/25 does not specify any fall precautions. On 6/18/25 at 2:30 PM, R2's Fall assessment dated [DATE] showed R2 was at high risk for falls. On 6/18/25 at 2:30 PM, Progress notes dated 5/25/25 at 4:05 AM showed, the nurse was alerted of the fall and observed resident on the floor laying across the legs of the sit to stand. On 6/18/25 at 12:20 PM, V8 (CNA) stated, she was by herself while transferring R2 on the sit to stand machine. V8 (CNA) stated, facility required two staff for the procedure. V8 (CNA) stated, after she sat R2 on the bed, as she was moving the machine to the side, R2 fell forward onto the floor and hit her forehead. On 6/18/25 at 11:40 AM, V10 (LPN-Licensed Practical Nurse) stated, two persons must be present to transfer a resident on a sit to stand lift machine. If not, there are chances of accidents / injuries. On 6/18/25 at 9:30 AM, V2 (DON-Director of Nursing) stated, on 5/24/25, at around 8:00 PM, V8 (CNA-Certified Nursing Assistant) was transferring R2 by herself using a sit to stand lift machine. After sitting R2 onto the bed, V8 (CNA) removed the straps and as she was moving the machine away, R2 fell forward from the bed onto the floor. On 6/18/25 at 9:30 AM, V2 (DON-Director of Nursing) stated, sit to stand transfer lift must be operated by 2 persons as per facility policy. On 6/18/25 at 3:00 PM, Facility reported incident was reviewed. No concerns. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility policy on 'lifting machine revised in 08/2008 showed the portable lift must be used by two staff members.