

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 12/04/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to implement safety and fall prevention interventions when transferring a resident during personal care. This applies to 1 of 8 residents (R7) reviewed for falls in a sample of 10 residents. Findings include: R7 is a [AGE] year-old female with a history of Dementia with Moderate Mood Disturbance, Seizures, Recurrent Major Depressive Disorder, Generalized Anxiety Disorder, Adjustment Disorder with Mixed Anxiety and Depressed Mood, Disorder of Muscle, and History of Falling who was admitted to the facility 04/19/2024. R7's current care plan shows she exhibits behaviors of combativeness, noncompliance with care, getting out of bed unassisted or not using call light for assistance, and shows she is at risk for falls due to behavior and to encourage compliance with transfer safety devices. On 11/24/2025 at 12:48 PM, R7 was seen sitting in the dining room eating her lunch with a large area of discoloration and bruising above her left eyebrow. R7's incident report dated 11/13/2025 shows at approximately 9:30 AM she had a witnessed fall while in the common bathroom and an open area above her left eyebrow bleeding was identified, she was being assisted to the toilet in the shower room, she raised off the toilet unassisted and legs buckled from under her and she fell, she was observed sitting on the floor in the shower room and confirms hitting her head, intervention of bringing R7 to the nurse station for close monitoring was implemented and R7 was sent to the hospital for assessment and later returned to the facility. Witness statement from V7 (Staffing Coordinator/Certified Nursing Assistant) dated 11/13/2025 documents R7 was trying to self-transfer to the shower room toilet, when assisting R7 with transferring off the toilet back to the wheelchair R7 began fidgeting and trying to pull up her own pants and her foot gave out from underneath her, and she fell and hit the left side of her head on the floor. On 11/24/2025 at 1:56 PM, V7 (Staffing Coordinator/Certified Nursing Assistant) said on morning of 11/13/2025, R7's roommate was in the restroom when R7 had to use the bathroom. According to V7, R7 became impatient and began going to the shower room to use the restroom. Once R7 was ready to be transferred off the toilet, upon standing up R7 insisted she would pull up her own pants and began arguing that she wanted to pull up her own pants; R7 began reaching down and became unstable on her legs; R7's legs gave out and she fell to the side, landed on floor and hit her head. V7 said she tried to break R7's fall but was unable to stop R7's fall. R7 fell and hit her head. V7 said on 11/25/2025 at 10:52 AM, that she was not using a gait belt when assisting R7 off the toilet. V7 said while she was assisting R7 from the toilet back to her wheelchair R7 was holding the grab bars, she let go to pull up her pants and lost her balance. V7 said when assisting R7 from the toilet she placed her arms around R7's back for support and R7 was braced against her. On 11/25/2025 at 2:44 PM, V3 (Restorative Director/Licensed Practical Nurse) said all aides are required to wear gait belts when transferring; when a resident has a fall, nursing completes a risk management assessment and based on the assessment and interviews regarding falls interventions are implemented, R7 requires one person assist for transfers during toileting and gait belts are to be used for toileting transfers. The facility's Policy on Gait Belt Use received 12/04/2025 shows: A gait belt is a safety device made of cloth that buckles securely around a resident's waist. The device provides a secure grasping surface to aid during transfer and ambulation. Commonly used for residents who are at risk for falls and those who require assistance during transfer. A gait belt can support a lower to the floor if the resident begins to fall or loses balance during transfer or ambulation. When combined with proper body mechanics a gait belt improves caregiver safety and prevents back injury.</p>		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations, interviews, and record reviews the facility failed to ensure food was prepared and served under sanitary conditions by not ensuring kitchen areas and equipment were maintained in a clean and sanitary condition, not performing hand hygiene when necessary, not wearing hair coverings appropriately, and not discarding spoiled food. This failure applies to all 100 residents eating food from the facility. Findings include: On 11/20/2025 at 10:09 AM, the kitchen hand washing sink was heavily stained with black residue, visible food spatter and particle residue was present on the hand soap and hand sanitizer dispensers above the hand washing sink, a heavy presence of dust was present on the paper towel dispenser above hand washing sink, dark gritty colored stains and residue was present on the lid, surface, and pedal of the garbage bin underneath hand washing sink. On 11/20/2025 at 10:12 AM, yellow stains and food spatter was present on the wall over food prep area with microwave located underneath. On 11/20/2025 at 10:16 AM, A red sticky substance was present on the surface of a large box of bagels in the kitchen deep freezer, and red spatter was present on inner rims and top of the door of two deep freezers. On 11/20/2025 at 10:23 AM, V10 (Cook) touched his mouth and continued with handling dishware and meal prep without performing hand hygiene. On 11/20/2025 at 10:32 AM, A heavy presence of dark gray, red, and black stains were present on the interior lip of the ice machine where ice is dispensed, a gray and white buildup was present on the rim underneath the ice machine lid, and white stains and smudges were present throughout the exterior of the ice machine. Heavy thick white stains were present on the food prep sink faucet. A large box of apples stored underneath the food prep table dated 10/28/2025 held multiple rotted apples. On 11/20/2025 at 10:40 AM, V14 (Dietary Aide) walked through the kitchen with her personal coat on and grabbed a personal cup from the food prep area where clean trays and cups were stored. On 11/24/2025 at 11:10 AM, V11 (Dietary Aide) observed rolling silverware with hair barely covered by hairnet. V11 said the hairnet didn't fit well and she needed a bigger one. On 11/24/2025 at 11:12 AM, V10 (Cook) touched his lips, placed his hand in his pockets, and continued preparing food in the kitchen without performing hand hygiene. Colored stains were present on the surface of the hand soap dispenser above the handwashing sink a heavy presence of dust and thick sticky white stains were present on the surface of the paper towel dispenser, and visible dust and food particles was present on the surface of the hand sanitizer dispenser above the handwashing sink. V9 (Dietary Manager/Consultant confirmed the presence of visible dust, particles, and stains on the hand sanitizer and soap dispensers and paper towel dispenser. On 11/24/2025 at 11:25 AM, V10 (Cook) said kitchen cleaning practices definitely need improvement. Multiple large cracks were present in the surface of the food processor bowl/pitcher sitting on the food prep sink. V9 said she could see the cracks in the food processor bowl/pitcher and that it is was leaking. Sticky stains and food spatter were heavily present on the wall behind the hotbox that was sitting on top of the food prep table, and a heavily stained blue basin was sitting directly behind the hotbox. Food particles and greasy stains were heavily present on the surface of the shelf underneath the food prep table where clean sheet pans were stored and on the meshed side wall of the shelf. Visible food spatter and stains were present on the back wall of the food prep table. Food spatter and grease stains were heavily present throughout the surface of the stove being used to cook a meal. V9 said she could see the food stains and particles throughout the food prep table and behind the hotbox. V8 (Dietary Manager) said the blue basin was old and should be thrown out. On 11/24/2025 at 11:36 AM, V8 (Dietary Manager) said the food processor bowl/pitcher was cracked and particles from the cracked material could get into the food being prepared using the food processor and kitchen appliances should be cleaned daily. The floors throughout the kitchen were heavily stained with a thick dark substance and food spatter and grease stains were heavily present throughout the surfaces of the stove area and the food prep sink areas next to the stove. On 11/24/2025 at 11:46 AM, Thick white removable stains were present on multiple dish racks filled with clean cups and sitting on food carts being used for dining service. On 11/24/2025 at 11:49 AM, Food particles were present on the surface of sheet pans with several clean plates sitting on them inside the plate warmer cabinet. Multiple visible white smeared stains were present on the front door of plate warmer cabinet. Food spatter and greasy stains were heavily present throughout the surface of the plate warmer machines filled with clean plates. Visible food particles were present throughout the surface of the overhead shelf above the steam table where all food being served for lunch was located. On 11/24/2025 at 12:20 PM, In the kitchen area visible thick food particles were present on various parts of the surface of three beverage pitchers with grape flavored beverage and</p>		