

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145793	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Renaissance Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 East Ash Street Canton, IL 61520	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33970</p> <p>Based on interview and record review the facility failed to ensure that one resident (R1) is free from abuse in a sample of three residents reviewed for abuse. This failure caused R1 to be visibly soiled through outer clothes and to have an odor.</p> <p>Findings Include:</p> <p>The Facility's Abuse Reporting policy dated 8/11/2017 documents This facility will not tolerate resident abuse or mistreatment by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, resident representative, legal guardians, friends or other individuals.</p> <p>The Abuse Reporting policy documents For the purposes of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish or by deprivation by an individual, including a caretaker, of goods or services that are necessary to attain ore maintain physical, mental psychosocial well-being. Willful Abuse: as used in this definition of abuse, mean the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental Abuse: Including, but not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services. Neglect/Mistreatment: means the failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance with activities of daily living that is necessary to avoid physical harm, mental anguish, or mental illness of a resident.</p> <p>A Complaint Form dated 5/22/24 documents that V9 (R1's Health Care Power of Attorney) complained that on the weekend of 5/17/24-5/19/24 she had stopped in and R1 smelled of urine and was not clean. The Follow Up section of the complaint documented Investigation and (State Agency) report completed. See (State Agency) final report.</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Final Report for Allegation related to (R1) dated 5/27/24 documents that R1 is alert with confusion and has a BIMS (Brief Interview for Mental Status) score of 2 (out of possible 15/indicating R1 is severely cognitively impaired) She uses a (reclining padded wheelchair) for mobility that is propelled by staff. She is able to utilize her right arm and will often raise it in the air. She is able to utilize her right arm and will often raise it in the air. She is also able to reach and grasp with her right arm/hand. (R1) has a current care plan for crying/being tearful, verbal aggression (yelling and cursing), physical aggression (grabbing and hitting) and pushing herself out of her (reclining padded wheelchair).</p> <p>The Final Report for Allegation related to (R1) dated 5/27/24 documents The following was noted (On 5/19/24) at approximate 5:45 PM V6 (Registered Nurse) came in for her shift and went to check (R1) because she had her arm up in the air. According to staff (R1) sometimes does this to indicate a need, though not consistently due to her confusion. When (V6/RN) checked (R1) she noted her to be wet and soiled, and she was slid down in her wheelchair. (V6/RN) immediately went to get a CNA to assist her in changing (R1) and laying her down. At approximately 6:00 PM (V6/RN) and (V5 Certified Nurse Aide) took (R1) to her room, changed her and laid her down. (V6/RN) asked (V3/RN) why the resident was sliding down in her chair and soiled. (V3/RN)'s response was that (R1) was having behaviors of aggression toward the staff who provided cares. (V6/RN) stated upon interview that (R1) was having no behaviors at the time she interacted with (R1) and was not having behaviors when she and (V5/CNA) provided cares. V3/CNA) was assigned to (R1) on 5/19/24 stated during her interview that (R1) had been having behaviors of yelling and screaming that day and the day before. She states she had been told to make sure (R1) was safe and leave her alone when these behaviors were occurring due to her being physically aggressive and bruising staff when she grabs and holds on.(V4/CNA) sated she noticed (R1) was when she was in the TV area by the nurses' station at approximately 2:20 PM and had asked the nurses if they wanted her to attempt to change (R1) and lay her down. (V3/CNA) was told by (V3/RN) not change her at that time due to the behaviors (R1) was exhibiting.</p> <p>The Final Report for Allegation related to (R1) documents that it was clear that (V3/RN) was not understanding the appropriate response to resident behaviors and ensuring cares are completed even during the occurrence of behaviors. It also became clear that she was not being truthful about her instructions and response to staff in regard to (R1) on 5/19/24.</p> <p>On 6/7/24 at 12:42 V8 (Administrator on call at the time of allegation) stated that she reviewed the video of the areas in question regarding the allegation with R1 on 5/19/24. V8 confirmed that R1 remained in her (reclining padded wheelchair) with no toileting and/or changing of her incontinent brief from the time she got up on 5/19/24 until V6 (Registered Nurse) and V4 (Certified Nurse Aide) took her to her room and changed her around 6:00 PM.</p> <p>On 6/7/24 at 11:30 AM V3 (Registered Nurse) seemed confused when asked about the allegation regarding R1 at the facility on 5/19/24. V3 stated what weekend are you talking about? I wouldn't remember all the details of a busy weekend. When asked why she was terminated from the facility V3 stated Oh, that. I told them that I didn't want the (staff) to have to get beat up just to change (R1)'s pants. (R1) was being very resistive that day and would keep saying no. If (staff working at the time of the incident) thought they should have changed (R1) that is on them, not me. They know how to do their jobs.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/7/24 at 11:10 AM V4 (Certified Nurse Aide) stated On that day (5/19/24) (R1) was being a little resistive in the morning after breakfast. So I made sure she was dry and positioned and didn't push it with her. When I went back after lunch I noticed she was slid down in her (reclining padded wheelchair) with foot part over the couch cushions. At about 2:00 PM I asked (V3/RN) about it and she said that she couldn't get (R1) to quit trying to get out of her chair. I told her I would go lay (R1) down and change her and (V3/RN) stated 'No, she can just stay there until she calms down.' V4 stated (R1) can be mean and yell and she does pinch sometimes, but I have never had to leave her wet like that before. V4 stated that at that time, 2:00 PM, R1 was visibly soiled and needed changed. V4 stated that she believed that she could have given cares to (R1) without being physically harmed. V4 stated that at 2:00 PM R1 was not having behaviors that V4 could observe.</p> <p>V6 (Registered Nurse) written statement dated 5/21/24 documents When I had come in for work it was about 5:45 PM and (R1) was positioned against the blue sofa, her feet were kind of over the sofa-she looked like she was sliding out of her chair and there was urine and fecal matter on her. I just, how she was, it wasn't appropriate, and that's why I went to (V8/Administrator on call) about it. I said something to (V3/RN) about it because she was on that side, about her sliding down in her chair and she said she's been having behaviors and I said when I walked over she just grabbed my hand, she wasn't having any behaviors. She (V3/RN) didn't have an answer to that.</p> <p>On 6/7/24 at 2:00 PM V6 (Registered Nurse) confirmed that she came in on 5/19/24 around 5:45 PM and found R1 visibly soiled through her clothes with visible BM (Bowel Movement) and food on her clothes and she smelled. V6 confirmed that V3 (Registered Nurse) told her that R1 had been having behaviors that prevented the staff from giving cares. V6 stated I wasn't comfortable with that, so I reported it. I have never had to leave a confused resident in that state before. If (R1) is having behaviors like the grabbing and pinching if you approach her on her left side she cannot reach you. (R1)'s behaviors usually mean that she needs something. V6 stated that when she and V5 (Certified Nurse Aide) changed R1 that she had no behaviors and was not resistive.</p> <p>On 6/7/24 11:15 AM V5 (Certified Nurse Aide) stated when I came in on that day (5/19/24) (V6/RN) told me to clock in and help her lay (R1) down. At that time (around 6:00 PM) (R1) stunk, and you could see that she was wet and messy. I ended up soaking off some of the BM (Bowel Movement) because it was dried into her skin. On a scale of 0-10 with 10 being the worse, she was a ten plus. It was nasty and I would be upset if my loved one looked like that. We have been trained on how to deal with behaviors, so I don't understand why (R1) would have had to have been left that bad ever. She had no behaviors when we laid her down and she had no behaviors when I did the extensive clean up.</p> <p>On 6/11/24 at 9:15 AM V9 (R1's Health Care Power of Attorney) stated I stopped in on the weekend it was either 5/19 or 5/20 and (R1) looked awful. I had my granddaughter with me, and she usually climbs up in (R1)'s lap and hugs her and she would not even get close to her because she stunk so bad. The smell was awful. I did ask staff and they told me she had been being mean, which I know she does sometimes. But it did bother me enough that I went ahead and reported it because I've never seen her that smelly and gross before.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970</p> <p>Based on interview the facility failed to ensure that one resident (R1) was free from physical restraint in a sample of three residents reviewed for abuse.</p> <p>Findings Include:</p> <p>The Facility's Physical Restraint policy dated 9/23/15 does not define situations that could be considered a physical restraint. The policy does document that the use of physical restraints shall be limited to situations necessary to maximize a resident's physical, mental and psychosocial wellbeing. Physical restraints shall be considered only after all alternatives to physical restraint usage has been documented as being ineffective in accomplishing a resident's care goals.</p> <p>The [NAME] Webster Dictionary defines a restraint as a device that restricts movement.</p> <p>R1's current care plan dated 12/26/2022 documents I will push myself out of my wheelchair at times. R1's care plan documents, When (R1) is pushing herself out of her wheelchair staff will assist her to her bed.</p> <p>V5(Certified Nurse Aide)'s written statement dated 5/21/24 documents that V5 reported to her shift supervisor that on 5/19/24 R1's wheelchair was pushed up against the couch.</p> <p>On 6/7/24 at 11:15 AM V5 (Certified Nurse Aide) stated when I came in on that day (5/19/24) (R1) was a mess and her chair was reclined back with the footrest over the seat of the couch. She was trying to get out of her chair, but she couldn't because the footrest wouldn't go down.</p> <p>On 6/7/24 at 11:00 AM V4 (Certified Nurse Aide) confirmed that she saw R1 in her reclining wheelchair with her footrest up over the seat of the couch. V4 stated that when she asked V3 (Registered Nurse) about it she was told that R1 had been trying to get out of her chair.</p> <p>V6 (Registered Nurse)'s written statement dated 5/21/24 documents When I had come in for work, it was about 5:45 PM and (R1) was positioned against the blue sofa, her feet were kind of over there on the sofa-she looked like she was sliding out of her chair.</p> <p>On 6/7/24 at 2:00 PM V6 (Registered Nurse) confirmed that on 5/19/24 R1 had been positioned in her reclining wheelchair with the footrest over the couch seat. V6 stated she didn't know how R1 got there. I do know that when she has behaviors she tries to climb out of her chair.</p> <p>V7(Registered Nurse)'s written statement dated 5/21/24 documents On that day (5/19/24) she (R1) kept trying to scoot out of her chair. The written statement documents Do you know anything about her (R1) being pushed up to the couch? I think (V3/Registered Nurse) put her there.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/7/24 at 12:42 PM V8 (Administrator on call on 5/19/24) stated that she reviewed video tapes of footage of R1 throughout the day on 5/19/24 related to a complaint voiced by V6 (Registered Nurse) and V9 (R1's Health Care Power of Attorney) related to R1's cares during the 6:00 AM-6:00PM shift on 5/19/24. V8 stated that she observed R1's reclining wheelchair reclined back with R1's footrest over the couch cushions. V8 confirmed that the footrest being in the position would prevent R1 from pushing the foot rest down. V8 stated that she did not know who put R1 in this position.</p> <p>V3 (Registered Nurse) written statement dated 5/20/24 documents We had a complaint related to (R1) being pushed up against the couch in her chair and They said she (R1) was there with her feet propped up on the couch-do you know anything about that? She was in her (padded reclining wheelchair). They said her (padded reclining wheelchair) was propped up on the couch. What? like her feet? that might have been. Have you seen that before? Not typically, but yesterday she kept pulling herself around.</p> <p>On 6/7/24 at 11:15 V3 (Registered Nurse) seemed to be confused when asked about the events that took place on 5/19/24 at the facility. V3 stated I can't remember the details of a busy weekend. When V3 was asked why she was terminated from the facility she stated Oh. That. yes, I know what you are talking about. V3 at first stated that R1 always tries to climb out of the bottom (footrest area) of her (padded reclining wheelchair). Later in the conversation V3 stated that R1 insisted that her footrest be positioned over the couch seats for comfort. V3 confirmed that the couch seat being under the footrest while not touching it does not affect R1's comfort in any way, that the wheelchair itself was supporting her foot area not the couch,</p> <p>The Final Report for Allegation related to (R1) dated 5/27/24 documents that after further discussion with (V3/RN) it was clear she was not understanding the appropriate response to resident behaviors and ensuring cares are completed even during the occurrence of behaviors. It also became clear that she was not being truthful about her instructions and responses to staff regarding (R1) on 5/19/24. V3 was terminated from employment.</p>		