

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  14E247	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/25/2025
NAME OF PROVIDER OR SUPPLIER  Joliet Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 2230 McDonough Joliet, IL 60436	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48526</p> <p>Based on observation, interview, and record review, the facility failed to maintain a residents room in good repair.</p> <p>This applies to 1 of 3 residents (R1) reviewed for physical environment.</p> <p>The findings include:</p> <p>R1 was admitted to the facility on [DATE] with multiple diagnoses which included schizoaffective disorder, attention deficit hyperactivity disorder, obesity, and tinea unguium. R1's MDS (Minimum Data Set), dated 02/10/25, showed R1 was cognitively intact.</p> <p>R1's Progress Note, dated 02/13/24 at 9:52 AM, showed, It was brought to writers attention that there was a hole in the wall by the resident's bed. Writer approached resident about the said behavior and incident and was educated that vandalizing facility property is not acceptable and will be held accountable.</p> <p>On 04/23/25 at 2:00 PM, R1 was in his room, sitting on the side of the bed. R1 was alert and oriented x3. R1 had a large piece of plywood on the wall next his bed. R1 stated he accidentally kicked the wall a year ago while he was sleeping. R1 stated the plywood has been there for a year. R1 stated the facility told him that they were going to repair it, but not when.</p> <p>On 04/24/25 at 9:20 AM, V6 (Maintenance Director) stated the plywood on the wall in R1's room measured 3 feet x 2 inches. V6 stated the plywood has been on the wall in R1's room since 02/13/24. V6 stated the hole has not been repaired in 14 months, due to him overlooking it. V6 stated the hole should have been repaired over a year ago.</p> <p>On 04/24/25 at 12:03 PM, V1 (Administrator) stated, (R1) punched a hole in the wall in his room on 02/13/24. The hole should have been fixed. It should not have been left with plywood on the wall for over a year. (R1) could get an injury from the plywood that is on the wall.</p> <p>The facility's Maintenance policy, effective date 04/2020, showed, The Maintenance Department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to: Maintaining the building in good repair and free from hazards. Establishing priorities in providing repair services.</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 - Minimal harm or potential for 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48526</p> <p>Based on interview and record review, the facility failed to protect a resident's rights to be free of sexual and physical abuse.</p> <p>This applies to 3 of 4 residents (R2, R3, and R4) reviewed for sexual and physical abuse.</p> <p>The findings include:</p> <p>R2 was admitted to the facility on [DATE] with multiple diagnoses which included post-traumatic stress disorder, schizoaffective disorder, anxiety, and borderline personality disorder. R2's MDS (Minimum Data Set), dated 02/13/25, showed R2 was cognitively intact.</p> <p>R3 was admitted to the facility on [DATE] with multiple diagnoses which included schizoaffective disorder, post-traumatic stress disorder, anxiety, insomnia, psychoactive substance use, depression, and seizures. R3 was discharged from the facility on 04/07/25.</p> <p>R4 was admitted to the facility on [DATE] with multiple diagnoses which included primary insomnia, schizoaffective disorder, bipolar disorder, cannabis use. R4's MDS, dated [DATE], showed R4 was cognitively intact.</p> <p>The facility's 04/05/25 Report to IDPH (Illinois Department of Public Health) showed R2 reported to the PRSC (Psych Rehab Services Counselor) that R3 touched her inappropriately by grabbing her left breast. R2 reported she kicked R3 after he touched her inappropriately, and he left the room. The police were called and arrived at the facility on 04/05/25 at 6:40 PM. The conclusion for final report: the facility believes that due to (R3's) diagnoses of severe mental illness, including schizoaffective disorder bipolar type, paranoia with accusatory statements, mixed with being intoxicated, the facility believes that (R3) was unable to control his impulses and proceeded to touch (R2) inappropriately.</p> <p>The facility's 04/07/25 Report to IDPH showed during an interview regarding a previous incident, R2 stated that she slapped her boyfriend, another resident (R4) on 04/05/25, because he didn't protect her from another peer who was inappropriate with her (R3). (R4) confirmed he was slapped, but stated that it didn't hurt. No injuries noted and (R4) denied pain. Resident declined police intervention. The MD (Medical Doctor) was notified with no new orders. The Final Report showed R4 declined police intervention. Conclusion for Final Report: the facility believes that due to (R2's) diagnoses of severe mental illness, including borderline personality disorder and bipolar disorder, mixed with being intoxicated, and angry and hurt from being violated, she reacted in an emotional manner and slapped her boyfriend.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/23/25 at 2:45 PM, R2 stated on 04/05/25, it was her birthday. She took a ride share to (retail store) and purchased an alcoholic beverage. R2 stated she wanted to turn up for her birthday with her boyfriend (R4) and her friend (R3). They all went outside and were drinking the alcoholic beverage. R2 and R4 went to R4's room. R2 stated they were lying in the bed. R2 stated she was tipsy, and they were not asleep. R2 stated R3 walked into the room and was talking with R4. R2 stated she was wearing headphones, so she did not hear what they were talking about. R2 stated R3 walked up to her and put his hand under shirt and grabbed her left breast. R2 stated she kicked R3 to move him away from her. R2 stated R3 walked towards her again, so she kicked him once again. R2 stated she thought R4 gave R3 permission to touch her, so she smacked R4. R2 stated she left the room and reported the incident to psych social staff. R2 stated the police were called and came to the facility.</p> <p>On 04/24/25 at 10:30 AM, R4 stated on 04/05/25, he and R2 were outside hanging out. R4 stated R3 came outside with them. R4 stated he and R2 went back inside to his room. R4 stated they were lying in the bed, and R3 came in the room. R4 stated he was rubbing on R2's stomach because she did not feel good. R4 stated R3 walked over and put his hands under R2's shirt and grabbed her breast. R4 stated R2 kicked R3 after he grabbed her breast. R4 stated R2 got mad at him and slapped him because R2 thought he let R3 grab her breast. R4 stated, I did not have a conversation with him and did not tell him he could do that.</p> <p>On 04/24/25 at 12:03 PM V1 (Administrator) stated all residents should be free from abuse and should feel safe in the facility.</p> <p>The facility's Abuse policy, effective date 12/2024, showed, The facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals .</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48526</p> <p>Based on observation, interview, and record review, the facility failed to have podiatry services provide foot care and treatment.</p> <p>This applies to 1 of 3 residents (R1) reviewed for podiatry services.</p> <p>The findings include:</p> <p>R1 was admitted to the facility on [DATE] with multiple diagnoses which included schizoaffective disorder, attention deficit hyperactivity disorder, obesity, and tinea unguium. R1's MDS (Minimum Data Set), dated 02/10/25, showed R1 was cognitively intact. The same MDS showed R1 required supervision or touching assistance with ADL's (Activities of Daily Living).</p> <p>On 04/23/25 at 2:00 PM, R1 was wearing black slippers. R1's toenails on his left foot were long, black, and curled in a downward position. R1's toenails on his right foot were long. R1 stated the last time he had his toenails clipped by the podiatrist was six months ago. R1 stated he told the program manager that he needed his toenails clipped. R1 stated he was on the list to see the podiatrist in March. R1 stated the podiatrist came and did not see him. R1 stated he wants his toenails clipped.</p> <p>On 04/24/25 at 12:03 PM, V1 (Administrator) stated R1 should have been provided with podiatry care. R1's toenails should not be long, hard, and discolored, and without care.</p> <p>On 04/24/25 at 1:16 PM, V4 (Director of Nursing) stated the podiatrist came to the facility on [DATE]. V4 stated R1 did not see the podiatrist on that day. V4 stated they did not have documentation showing R1 refused to be seen. V4 stated the facility should have made sure R1's toenails were clipped, if that meant sending him to a podiatrist outside of the facility.</p> <p>The facility's podiatry list showed R1 was added to the podiatry list on 03/03/25 to have his toenails trimmed. The facility was unable to provide documentation of R1 being seen in 03/2025 by the podiatrist.</p> <p>The facility's Podiatry Services policy, effective date 03/2021, showed The facility will make available podiatry services to all residents. Comprehensive foot care by a podiatrist includes prevention of infections and trimming of mycotic/ingrown toenails .</p>		