STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENWICK NURSING AND REHAB	3401 HENNEPIN DRIVE JOLIET, IL 60435

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S 000	Initial Comments Annual Licensure and Certification Investigation of Facility Reported Incident of 09-28-25024/IL179035	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to do background checks on staff before they were hired to work at the facility. This applies to all 92 residents that reside in the facility. Findings include: On October 21, 2024, at 10:40 AM, V1 (Administrator) documented on the CMS-671 form that there were 92 residents residing in the facility. Review of hire dates for V27 (Housekeeper) and V28 (Certified Nursing Assistant) showed that V27 was hired on September 12, 2024, and V28 was hired on April 26, 2024.	S9999		

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On October 22, 2024, at 9:45 AM, V23 (Human Resource Coordinator) stated that between March and September of 2024 she did not have access to the state's site to run background checks, therefore, she asked corporate to do background checks. V23 stated she does not have the copies of any background checks for V27 and V28. V23 stated that she will reach out to corporate to get them.

On October 23, 2024, at 12:07 PM, V23 stated that they did not have background checks for V27 and V28. V23 stated she started running the background checks yesterday (October 22, 2024) and will have V27's background checks done today (October 23, 2024).

On October 23, 2024, at 02:25 PM, V3 stated that V27's health care registry came back with work eligibility, not yet determined. V23 stated that V27 has been working at the facility since September 12, 2024. V23 stated that V27 should have been fingerprinted before September 12, 2024.

Review of V28's background check showed it was initiated on October 22, 2024. Review of V27 background check showed it was initiated on October 23, 2024.

The facility's Background Screening Investigations dated December 2006 showed the following: 1. The Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference checks, and criminal conviction checks (Including fingerprinting as may be required by state law) on persons making application for employment with this facility. Such investigation will be initiated in accordance with state regulatory guidelines

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S9999	Continued From page 2 pertaining to employment or offer of employment. (C) Statement of Licensure Violations 2 of 2: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general	S9999		

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nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow therapy's recommendations for safe transfer of a resident.

This failure resulted in R345 sustaining a laceration on R345's left leg requiring six sutures due to an improper transfer.

This applies to 1 of 3 residents (R345) reviewed for resident injury in the sample of 19.

The findings include:

The EMR (Electronic Medical Record) showed R345 was admitted to the facility on April 25, 2024, with multiple diagnoses including dementia, peripheral vascular disease, heart failure, and lymphoid leukemia.

R345's MDS (Minimum Data Set) dated August 9, 2024, showed R345 had severe cognitive impairment. The MDS continued to show R345 required substantial assistance from facility staff for bed to chair transfers.

R345's ADL (Activity of Daily Living) care plan dated June 6, 2024, showed, "The resident has

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an ADL self-care performance deficit needs and participation may vary related to cognitive deficits, impaired speech, weakness." The care plan continued to show multiple interventions dated June 6, 2024, including "Mechanical lift for transfers."

On October 22, 2024, at 2:16 PM, V15 (CNA/Certified Nursing Assistant) said on September 28, 2024, V15 transferred R345 by herself using a gait belt. V15 continued to say R345 scraped his left leg into the wheelchair and then she noticed some bleeding from his leg and alerted the nurse. V15 said R345 was supposed to be transferred with a mechanical sit-to-stand lift with two facility staff members. V15 continued to say R345 had very fragile skin and V25 needed to be very careful when transferring R345. V15 said the transfer was a part of routine care and there was not an emergency.

The facility's "Facility Incident Report Form" completed by V2 (DON/Director of Nursing) on September 28, 2024, showed, "Description of Occurrence: Resident who is alert times one, was observed with bleeding from his left lower leg during transfer from bed to his wheelchair. Left lower leg was cleansed and dressing applied, and resident was assessed for pain, no pain observed or reported. Physician was called and orders were given to send resident to hospital for evaluation and treatment. Family notified of incident and new orders. Resident was sent out to hospital. Resident has returned back from hospital with six sutures to left lower leg, pain assessment completed, and pain being managed appropriately per orders. Investigation in process. Occurrence Resolution: During transfer with staff aide on September 28, 2024, [R345]'s left lower extremity came in contact with the top

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of his leg rest on wheelchair resulting in skin alteration to left lower extremity, resident is taking anticoagulant, and orders were received by primary care clinician to send to hospital for evaluation and treatment. [R345] has returned back to facility after receiving treatment at hospital for laceration to left lower extremity. Six sutures were applied to left lower extremity that will be removed in 10 days in house by wound care nurse, extremity is assessed every shift for change in condition. Primary care clinician aware of new orders and family also made aware. Pain assessed and managed appropriately per orders. Cushion has been applied to top part of leg rest. Therapy to screen for transfers. Plan of care updated to reflect changes."

On October 22, 2024, at 2:57 PM, V16 (Director of Rehab) said R345 was discharged from Physical Therapy and Occupational Therapy on August 9, 2024. V16 said upon R345's discharge from therapy, therapy's recommendations were for facility staff to utilize a mechanical sit to stand lift. V16 continued to say two facility staff members are required when using a mechanical sit to stand lift. V16 said facility staff are to follow the special instructions shown in the resident's EMR. V16 said R345's EMR showed R345 was a mechanical sit to stand transfer. V16 continued to say it is the expectation facility staff follow therapy's recommendations for a safe transfer.

On October 22, 2024, at 3:32 PM, V17 (Nurse Practitioner) said it is the expectation that facility staff follow therapy's recommendations for a resident's safe transfer. V17 continued to say facility staff should have transferred R345 per therapy's recommendations to prevent R345 from getting injured.

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S9999	Continued From page 6 On October 23, 2024, at 3:40 PM, V2 said facility staff should be following the special instructions in the EMR for how a resident should be transferred. V2 continued to say V15 should have transferred R345 with a second facility staff member using a mechanical sit to stand lift. R345's hospital records dated September 28, 2024, showed R345 had a leg laceration requiring sutures. The facility's policy titled "Safe Lifting and Movement of Residents" dated August 2008, showed "Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care this facility uses mechanical lifting devices for the lifting and movement of residents. Policy Interpretation and Implementation: 1. Mechanical lifting devices shall be used for any resident needing a two person assist. Except during emergency situations or unavoidable circumstances, manual lifting is not permitted ... 7. The transferring needs of residents shall be assessed on an ongoing basis. Resident transferring and lifting needs shall be documented in the care plan ..." (B)	S9999		