STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure and Certification	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.650c) 300.650d) Section 300.650 Personnel Policies c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the Individual's personnel file. d) The facility shall check the Health Care Worker Registry for the work eligibility status of all applicants who are under the jurisdiction of the Healthcare Worker Background Check Act prior to hiring. This requirement was NOT met as evidenced by: Based on interview and record review, the facility failed to maintain documentation of review of the IDFPR (Illinois Department of Professional Regulations) and have a copy of nursing license for 2 nursing staff. The facility also failed to provide documentation that employee background checks were completed prior to working for 2 staff members. This failure affects all 103 residents residing in the facility. Findings include: The facility employee list shows V12's (Wound Technician) hire date of 5/28/25. Documentation of V12's background checks for Illinois Department of Public Health Care Worker Registry was reviewed on 8/5/25.	S9999		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 1 The facility employee list shows V27's (Housekeeper) hire date of 8/13/25. Documentation of V27's background checks for Illinois Department of Public Health Care Worker Registry was reviewed on 9/11/25 (during the survey). The IDFPR website review was dated 9/11/25 for V24 RN (Registered Nurse) and V28 LPN (Licensed Practical Nurse). On 09/11/2025 at 11:58 AM, V29 Regional Human Resource Consultant stated he had conducted an audit and found the backgrounds checks for V12 had not been completed by the previous HR (Human Resource) staff. V29 stated he did not have access to the files on the HR computer, so he re-ran the background on V27. V29 stated he was had the understanding that copies of nursing licenses were not required. V29 stated he reviewed the IDFPR when documentation was requested today. The undated facility policy Background Checks states the HR director, or designee will ensure completion of background checks for all new employees and as required be the respective state of center operations. (C) Statement of Licensure Violations 2 of 3: 300.615e) 300.615f) 300.615j) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 2 Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. This requirement was NOT met as evidenced by: Based on interview and record review, the facility failed to perform documentation checks within 24 hours on the CHIRP (Criminal History Information Response Process) website, Illinois sex offender registry, and the Illinois Department of Corrections. The facility also failed to take necessary steps to ensure the safety of residents from an identified offender while the results of a fingerprint-based background check was pending. This applies to 5 of 10 residents (R112, R52, R111, R113 and R28) reviewed for background checks. This failure affects all 103 residents residing in the facility. Findings include: 1.R28's face sheet shows an admission date of 8/28/25. R28's CHIRP documents a criminal history hit. The facility did not of documentation as to the nature of R28's criminal history. R28 did not have a risk assessment completed the state investigator. V25 Admissions Director stated she is responsible for assuring resident background checks are completed and documented. V25 stated the CHIRP for R28 returned with hits but it didn't specify what the criminal offenses were. V25 stated R28 had a roommate, but they did not need to provide her with a private room until they knew what the criminal offenses were. On 09/11/2025 at 3:30 PM, V26 Social Services stated R28's CHIRP did not list her charges, and they were unaware of what her crimes were. V26 stated the fingerprinting for R28 had been done, but she had not been assessed by the state investigator. V26 stated she talked to R28 and assessed her, and she is friendly. V26 stated she did not see a reason why R28 should not	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 3 have a roommate. On 09/11/2025 at 3:35 PM, V1 Administrator stated if a resident CHIRP returns with hits, and they are unaware of what the criminal offenses are that resident should not have a roommate. V1 stated had he been notified he would have made a private room available. V1 stated it is in the interest of both residents to provide a private room for the resident with unknown criminal offenses. The undated facility policy Identified Offender Facility Policy and Procedure states it is policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal history. While the background or fingerprint checks, waiver request, and or identified offender report recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents. 2. R112's face sheet shows an admission date of 9/8/25. The facility did not provide dated documentation for review of the Illinois Sex Offender Registry or the Illinois Department of Corrections. 3. R52's face sheet shows an admission date of 8/14/25. The facility did not provide a dated CHIRP for R52. 4. R111's face sheet shows an admission date of 9/2/25. The facility did not provide dated documentation for review of the Illinois Sex Offender Registry. 5. R113's face sheet shows an admission date of 9/3/25. The facility did not provide dated documentation for review of the Illinois Sex Offender Registry. (C) Statement of Licensure Violations 3 of 3: 300.610a) 300.1210b)4) 300.1210c) 300.1210d)2) Section 300.610 Resident Care Policies	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 4 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. These Regulations are not met as evidenced by: Based on observation, interview, and record review, the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 5 facility failed to monitor and assist a resident with a known risk for malnutrition with restoring her oral eating skills and failed to provide gastrostomy tube management and care as ordered for a resident who was dependent on enteral nutrition. This failure resulted in R6 experiencing a significant weight loss of 5.8% in one month. This applies to 1 of 1 resident (R6) reviewed for gastrostomy-tubes in a sample of 29. The findings include: On 9/09/2025 at 11:10 AM and 12:20 PM, R6 was in bed sleeping. R6's piston syringe was sealed and a measuring cylinder for her g-tube (gastrostomy-tube) feeding were on her bedside table, unused. At 2:40 PM, R6 was still in bed and unable to fully express or communicate regarding her tube feedings. R6 contacted V17 (Family Member) via her cell phone to assist her with her communication. V17 said they were concerned for R6's nutrition because R6 would report that she did not always receive her scheduled feedings as ordered, and the facility would then report R6 refused her tube feedings at times because she wanted to resume eating orally. V17 continued to say that R6 was receiving ST (Speech Therapy) services and was informed weeks earlier that R6 would be receiving a video swallow study to determine if she could resume eating orally. On 9/10/2025 at 12:00 PM, R6 was in bed awake. R6 gestured that she had not received her scheduled 11 AM bolus feed. R6's still-sealed piston syringe and a measuring cylinder for her g-tube feeding were both on her bedside table, unused. R6's EMAR (Electronic Mediation Administration Record) showed V11 (Licensed Practical Nurse/LPN) had signed off R6's scheduled 11 AM bolus feed and water flush as having already been administered. At 12:50 PM, V11 confirmed she had not administered R6's scheduled bolus and water flush as ordered, and she had pre-signed R6's EMAR. V11 said she would administer R6's bolus feed of Glucerna 1.5, close to two hours late. V11 failed to assess R6's tube site, check for placement, or check for GRV (gastric residual volume). V11 proceeded to flush R6's tube with 30 ml (milliliters) of water, then 340 ml of Glucerna 1.5, and then another 40 ml of water. V11 said she was done administering R6's scheduled feeding. R6's Order Review Report dated 9/11/2025 showed g-tube orders for enteral feed Glucerna 1.5 give 340 ml bolus every 6 hours, flush feeding tube with 375 ml of water every 6 hours, observe peristomal skin for gastric leakage every	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 6 shift, and check for placement prior to feeding administration by aspirating for gastric residual feeding. V11 said R6 at times would indicate if she was unable to tolerate her full bolus feeds, stating "when she felt too full." V11 said R6 was completely NPO (nothing by mouth) and was not sure about the status of R6's swallow study. R6's Electronic Medical Record (EMR) showed R6's 8/9/2025 weight was 140.1 pounds, and her 9/1/2025 weight was 142 pounds. On 9/11/2025 at 10:30 AM, V10 (LPN) said he weighed R6, and she weighed 132 pounds. On 9/11/2025 at 1:40 PM, V2 (Director of Nursing/DON) said nurses were expected to follow g-tube orders as indicated and follow facility policy to ensure residents with g-tubes received appropriate enteral feeding cares. On 9/11/2025 at 11:30 AM, V16 (Speech Language Pathologist/SLP) said she was treating R6 for her communication and swallowing goals. V16 said she had difficulty fully assessing R6's level of cognition, and at times she would display behaviors of refusing speech therapy (ST) education. V16 said R6 was supposed to have an outpatient video swallow study weeks earlier to evaluate if she could safely resume her desired oral diet. V16 said she was concerned because she had not received updates from the facility staff on when R6's swallow study would be scheduled. V16 said at the moment, she had not been able to advance in R6's ST goals for eating because the study had not been done. V16 said she reviewed R6's EMR and was unable to find documentation of any attempt that had been made to schedule R6's swallow study. R6's September 2025 Physician Order Sheet (POS) showed an 8/20/2025 active order for "Video Fluoroscopic Swallow Study (VFSS) Modified Barium Swallow Study." On 9/11/2025 at 12:05 PM, V15 (Dietician) said she was monitoring R6's nutrition. V15 said on 8/29/2025, she had assessed R6's nutritional needs and was informed she was refusing her bolus at times because she wanted to resume her oral feeding. V15 said she did not make any further nutritional recommendations and believed R6 would be having her video swallowing study. V15 said that now based on R6's identified significant weight loss of 5.8% in 1 month, she was initiating continuous g-tube feedings to ensure R6's feedings maintained her nutritional needs. V15 said she assumed the facility nursing staff and ST would be following up with the scheduling of R6's video swallow to determine if she could safely resume her oral intake. V15 said on 8/29/2025, R6's weight was not being monitored weekly	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058412	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 7 because her weight had been stable and R6 was not identified as at risk for weight loss. V15 said residents at risk for weight loss should be weighed and monitored weekly to identify and prevent significant weight loss. V15 continued to say R6 should have received her g-tube feeding and hydration flushes as ordered to ensure she received appropriate hydration and nutrition to meet her needs. R6's 8/29/2025 dietary note showed R6's nutritional needs were reviewed. The note showed "Resident noted refusing g-tube bolus at times [related to] stated wanting to eat by mouth. There is an order for a swallow study…Plan: Continue present management follow up prn." R6's 9/11/2025 dietary note (during the survey) showed R6 was referred for significant weight loss of 5.8% in 1 month. The note said "Resident noted [history] refusing g-tube bolus at times [related to] stated wanting to eat by mouth. Tolerates enteral feeding. [Inter-disciplinary Team] suggesting trialing continuous enteral feeding…Recommend 1) Glucerna 1.5 @ 75 ml/hr x 18 hours; 2) Flush: 300ml [every] 6 hrs; 3) Weekly weights x 4 weeks." R6's care plan showed R6 was refusing her g-tube feedings and was at risk for weight loss. The interventions included "Order Video Swallow as ordered or recommended" and Provide supplements as ordered." The facility's 9/2022 Enteral Tube Care and Maintenance policy showed "Daily care of the gastrostomy/jejunostomy tube and exit site will extend the life of the tube, prevent peristomal skin irritation, and assure appropriate hygiene of the tube exit site…Verify feeding tube placement as appropriate…Check for placement prior to medication, flush or feeding administration...." The facility's 6/2023 Interventions for Unintended Weight Loss policy showed "It is the policy of [Company] that individuals with unintended weight loss or insidious weight loss will be identified and monitored so that appropriate intervention can be implemented...." (B)	S9999		