STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145989	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parker Nursing & Rehab Center	516 West Frech Street Streator, IL 61364

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on interview and record review, the facility failed to ensure the resident's Power of Attorney (POA) was notified post fall for one of three residents (R2) reviewed for falls. Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 3/11/25, were reviewed. The Census Roster documented 60 Residents resided in the Facility. Guidelines for Notification of Change in Residents Condition/Status/Treatment dated 6/29/24 documented the nurse will immediately notify the resident, their physician, and/or the resident's Responsible Party/POA for the following: a) An accident involving the resident, which results in injury and has the potential for requiring physician intervention. B) A significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental, or psychosocial status in either life threatening conditions or a clinical complication. Guidelines for Incident/Accidents/Falls dated 6/30/23 documented residents who have an unwitnessed fall must have neurological checks started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed (by staff) fall. The nurse will notify the resident's attending physician and resident's power of attorney and documented in the progress notes. R2 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarct affecting right dominant side, Morbid Obesity related to excessive caloric intake, Diastolic Congestive Heart Failure, Hypertension, Diabetes Mellitus Type 2 and End Stage Renal Disease dependent on Hemodialysis. R2's Nurse's Progress Note dated 10/7/24 at 10:50 AM documented R2 fell out of his wheelchair while being mechanically lifted in his wheelchair into the NCAT (North Central Area Transport, public transportation service) van. R2 stated he hit his head although refused to go to Emergency Department for evaluation and proceeded to be transported to the off-site dialysis unit and for dialysis treatment. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dialysis Center's Nurse's note date 10/07/24 at 3:04 PM documented at the beginning of tx (dialysis treatment), pt (R2) stated that he fell while in the (public transportation van) (documented in chairside). I asked pt (patient) if he hit his head, pt (R2) denied. no wounds or welts noted. during tx, pt (R2) stated his back was hurting d/t (due to) the fall, gave prn (as needed) tylenol. pt (R2) then called POA (V18) and told him that he hit his head during the fall. I called pt's (R2) NH (Nursing Home) staff and got the full story. pt (R2) did fall, did not hit head per (the public transportation service/van) driver and pt (R2) was checked out by staff. pt refused to go to the ER and stated that he was fine. Advised NH staff to call pt's (R2) POA (V18) for an update as they had not called him after the fall. R2's Nurse's Progress Note dated 10/7/24 at 4:11 PM (after dialysis unit's staff notified V18 (R2's Power of Attorney/POA) documented an attempt to reach V18 was made and a message was left. On 3/14/25 at 8:08 AM, V17 (Dialysis Clinic Manager) stated R2 told the dialysis nurse about the fall and the dialysis unit was not notified by the Long Term Care Facility prior to initiating dialysis treatment on 10/7/24. R2 requested V18 (R2's POA) to be called/notified of the fall and his increasing pain. V18 stated he had not been called by the Long Term Care Facility and was unaware of R2's fall. On 10/7/24 at 3:05 PM, the dialysis nurse called the Long Term Care Facility to get a report about the fall incident and to inform the Facility about R2's complaints, treatment and the notification made to V18. R2's census data documented R2 was discharged from the facility on 11/8/24. The medical record did not include documentation to describe why R2 left the facility, where R2 was discharged to or that V18 or a physician was notified. R2's Hospital Discharge Summary dated 11/28/24 documented on 11/8/24 R2 presented to the Emergency Department with shortness of breath, generalized weakness, low blood pressure and heart rate; was admitted to the Intensive Care Unit for Septic Shock. The Summary documented R2 continued to deteriorate and V18 transitioned R2 to hospice and passed away on 11/28/24 at 3:15 AM. On 3/13/25 at 12:15 PM, V1 (Administrator) stated the resident's physician and POA's should be notified as soon as possible when a change in condition occurs. V1 also stated she would have expected facility staff to notify the dialysis staff about R2's fall to ensure R2's safety.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on interview and record review, the facility failed to ensure residents were assessed after a fall per policy and interventions were implemented to prevent further falls for one of three residents (R2) reviewed for falls. Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 3/11/25, were reviewed. The Census Roster documented 60 Residents resided in the Facility. Guidelines for Incident/Accidents/Falls dated 6/30/23 documented residents who have an unwitnessed fall must have neurological checks started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed (by staff) fall. Documentation of the physical and mental status of the resident(s) involved will be completed each shift (every 8 hours minimally) over at least 72 hours or until the resident's condition improves. Neuro checks will be completed after any head trauma as well as after any unwitnessed fall (even if the resident states they did not hit their head) as per policy. All falls will have a site investigation by appropriate staff in an effort to define the root cause of the fall. This will help provide information to enable staff to roll out interventions to prevent another similar occurrence. Each fall needs a new care plan intervention rolled out. Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate intervention in place. The occurrence will be documented. The progress note within the resident's medical record is to be included. Documentation in the medical record should include a description of the occurrence. The Neuro (Neurological) Check policy not dated documented it is the policy of the facility to ensure that if it is known or suspected that a resident has had a blow to the head, neurological complications are assessed to include neuro checks. Neuro checks will be performed for a minimum of 72 hours. Always do neuro checks if the fall was unwitnessed by the staff member even if the resident themselves or other residents state that the resident who fell did not hit their head before or after or during the fall. Vital signs and neurological signs are taken and recorded as follows: Blood Pressure (BP) and pulse and pupil check every 15 minutes for two hours; BP and pulse and pupil check every 30 minutes for two hours; BP and pulse and pupil check every 60 minutes for four hours; then continue vital sign and neurological checks every eight hours until 72 hours have lapsed and resident is stable. Long Term Care Facility Outpatient Dialysis Services Coordination Agreement dated 1/24/18 documented the Renal Dialysis Services shall not include transportation to the ESRD (End Stage Renal Disease) resident to and from the ESRD Dialysis Unit. Transport of the ESRD Resident is the Long Term Care facility's responsibility to arrange for suitable and timely transportation of the ESRD resident to and from the ESRD Dialysis Unit, including the selection of the mode of transportation, qualified personnel to accompany the ESRD Resident, transportation equipment usually associated with this type of transfer or referral in accordance with applicable federal and state laws and regulations and all costs or transportation expenses associated with such transfer. (continued on next page)

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(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	R2 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarct affecting right dominant side, Morbid Obesity related to excessive caloric intake, Diastolic Congestive Heart Failure, Hypertension, Diabetes Mellitus Type 2 and End Stage Renal Disease dependent on Hemodialysis. R2's Nurse's Progress Note dated 10/7/24 at 10:50 AM documented R2 fell out of his wheelchair while being mechanically lifted in his wheelchair into the public transportation van. R2 stated he hit his head although refused to go to Emergency Department for evaluation and proceeded to be transported to the off-site dialysis unit and for dialysis treatment. R2 returned to the facility after dialysis on 10/7/24 approximately 4:00 PM-4:30 PM (5-5 1/2 hours post fall). The medical record did not indicate that dialysis staff were notified of the fall and to conduct neuro checks. The medical record did not indicate neuro checks were conducted or vital signs were monitored until 11:45 PM prior to the transfer to hospital for severe pain related to fall. The Hospital's Discharge Summary documented R2 was admitted on [DATE] with diagnoses of subdural hematoma (brain bleed) and a T8 fracture (a thoracolumbar burst fracture caused by high-energy trauma) and was discharged back to the facility on [DATE]. The Facility Reported Incident dated 10/14/24 documented R2's wheelchair wheeled backwards when the mechanical lift reached the van door due to not having the wheelchair brakes locked. The Care plan was updated to ensure facility staff transport resident in facility bus when available. If facility staff/bus is not available then, facility staff will stay with resident while the public transportation staff load residents into the van to ensure the public transportation staff are doing so in a manner that was safe for the resident. New interventions were discussed with the Interdisciplinary Team, R2 and V18 (R2's Power of Attorney/POA). R2's Care plan dated 9/26/24 revised on 10/3/24 documented R2 was a risk for falls. An intervention initiated on 11/4/24, 23 days after R2 returned from hospital post fall, noted facility staff would accompany R2 out to the bus to ensure driver had locked R2's wheelchair and R2 was situated securely and safely in the bus prior to driver leaving. An intervention dated 9/26/24 documented I would like staff to review information on my past falls and attempt to determine the cause of my fall(s). Record possible root causes on my care plan. Alter/remove any potential causes it (msp. if) possible. Educate me, caregiver and IDT (Interdisciplinary Team) as to the continued risk factors and interventions used to help prevent future falls. The Care plan meeting note dated 10/16/24 documented R2 was in attendance and alert and oriented and able to make his needs known. Takes meds (medications) without difficulty. Has dialysis 3 x (three times) week. No skin issues noted. Appetite good. Does participate in Restorative with ROM (Range of Motion) and Dressing. Needs Limited/Partial assist with ADLs (Activities of Daily Living). BIMS 14/15 (Brief Interview for Mental Status, no cognitive impairment) FULL CODE. The note did not indicate the IDT, R2 or V18 (R2's POA) was notified of the new interventions to ensure a safe transport to dialysis. (continued on next page)

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(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	On 3/12/25 at 11:20 AM, V2 (Director of Nursing) stated We had someone (staff member) go out (outside when R2 was getting on the public transportation van) and physically watch to make sure they (the public transportation staff) put on the brakes (R2's wheelchair) and dialysis made sure brakes were on before he (R2) left there (dialysis facility). V2 stated the facility had not put an intervention in place to ensure all residents in a wheelchair who get into the public transportation van have their brakes on and stated That's not our job. On 3/12/25 at 2:00 PM, V2 verified post fall assessment had not been conducted on R2 after returning to the facility post dialysis. On 3/14/25 at 8:08 AM, V17 (Dialysis Clinic Manager) stated V17 nor dialysis staff were notified or asked by the Long Term Care facility to have the dialysis staff ensure R2's brakes were on prior to transport by the public transportation van. V17 stated We would never agree to that. Our staff does not ever leave the facility to assist with transport. Residents are responsible for their own transportation. On 3/12/25 at 9:25 AM, R5 (Dialysis resident) stated facility staff do not assist him out of the building to the public transportation van or ensure he gets onto the van safely. R5 stated he is independent and puts his own brakes on but he forgot about a month ago and almost fell forward when the public transportation van's ramp was lifting. The public transportation staff put his brakes on at that point. R5 stated he did not fall but it was scary. He previously has had two falls at the facility and stated staff did not assess him after the fall. On 3/14/25 at 11:55 AM, V1 (Administrator) indicated the public transportation service/van is responsible for their staff's education on safety of their equipment. There was not a contract in place between the facility and the public transportation service/van because the public transportation service/van was a public transportation service in which the residents pay for. V1 agreed the dialysis staff should have been notified of R2's fall, post fall assessments should have been conducted, fall interventions should have been implemented and R2 and V18 (R2's POA) should have been notified of the interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on interview and record review, the facility failed to ensure documentation was accurate and completed per policy for one of three residents (R2) reviewed for falls. Findings include: The Facility Resident Census Roster and Facility Matrix/802, dated 3/11/25, were reviewed. The Census Roster documented 60 Residents resided in the Facility. The Guidelines for Nursing Documentation policy dated 5/17/23 documented 6. Be timely in your documentation. It is easy to forget details in the hustle of business. 7. Late notes happen. Should you need to document something out of time do it properly and in orderly manner by first documenting when you are making the late note, then detailing the actual time the event occurred. Never be deceptive and back-date or fake that you are writing at an earlier time. 8. Flow Charts need filled. Every organization has flow charts, do not leave them blank. Also, whenever an unusual event occurs remember to also go to the chart to document your findings. 9. Remember if you did not write it down, you did not do it. If you did not do it, you were negligent. Guidelines for Incident/Accidents/Falls dated 6/30/23 documented documentation of the physical and mental status of the resident(s) involved will be completed each shift (every 8 hours minimally) over at least 72 hours or until the resident's condition improves. The occurrence will be documented. The progress note within the resident's medical record is to be included. The report will be completed as soon as information is obtained. The record should be finished as much as possible before the nurse ends the shift. Documentation in the medical record should include a description of the occurrence. The Neuro (Neurological) Check policy not dated documented that it is the policy of the facility to ensure that if it is known or suspected that a resident has had a blow to the head, neurological complications are assessed to include neuro checks. Neuro checks will be performed for a minimum of 72 hours. Always do neuro checks if the fall was unwitnessed by the staff member even if the resident themselves or other residents state that the resident who fell did not hit their head before or after or during the fall. Observe the resident for obvious injury to the scalp such as laceration/contusion/bruising, confusion, memory loss, difficulty speaking, vomiting, sleepiness/difficult to arouse, seizure or seizure like activity, weakness and/or inability to move an extremity, irregular breathing, gait or balance problems, blurred or double vision and/or periods of coherence alternating with periods of lethargy. Vital signs and neurological signs are taken and recorded as follows: Blood Pressure (BP) and pulse and pupil check every 15 minutes for two hours; BP and pulse and pupil check every 30 minutes for two hours; BP and pulse and pupil check every 60 minutes for four hours; then continue vital sign and neurological checks every eight hours until 72 hours have lapsed and resident is stable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2 was admitted on [DATE] with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarct affecting right dominant side, Morbid Obesity related to excessive caloric intake, Diastolic Congestive Heart Failure, Hypertension, Diabetes Mellitus Type 2 and End Stage Renal Disease dependent on Hemodialysis. The Incident Note describing R2's fall dated 10/7/24 at 10:50 AM, although was completed on 10/9/24 at 3:06 PM, greater than two days after R2's fall and discharge to the hospital, by V2 (Director of Nursing). The Progress Note stating R2 refused to be transferred to the hospital was dated 10/7/24 at 10:50 AM, although was competed on 10/10/24 at 7:33 AM, three days after R2's fall and discharge to the hospital, by V2. R2's Medication Administration Record documented on 10/8/24 at 8:00 AM the following Medications were administered and Treatments were provided, although R2 was not in the facility (discharged to hospital on 10/7/24 at 11:45 PM and returned to the facility on [DATE]): Medications administered: Sevelamer Carbonate, Eliquis, Vitamin D-3, [NAME]-Vit, Jardiance, Gabapentin, Clopidogrel Bisulfate. Treatment administered: monitored hemodialysis arterial-vascular fistula site for redness, swelling, pain, bleeding, bruit and thrill; documented fluid intake as 480 milliliters; was on Enhanced Barrier Precautions and obtained a blood sugar level of 164. The Facility Reported Incident (FRI) dated 10/8/24 documented R2 had a fall and hit his head on 10/7/24, refused to go to the Emergency Department and went to dialysis as scheduled and per dialysis staff R2 denied pain or discomfort during treatment, post return to the facility monitoring of condition continued. R2 was sent to the Emergency Department for complaints of pain on 10/7/24 at 11:45 PM and was admitted with diagnoses of a thoracic spine fracture and subdural hematoma (brain bleed). R2's medical record did not include the time of day R2 returned from dialysis on 10/7/24 or that ongoing monitoring was conducted as documented on FRI. R2's Progress Note dated 10/31/24 at 11:21 PM documented R2 was sent to the Emergency Department. The medical record did not include documentation to describe R2's condition, signs and symptoms or assessments related to the reason for transfer and did not include a note, date or time that R2 returned to the facility or that an assessment was conducted upon return. R2's census data and Minimum Data Set (MDS) documented R2 was discharged from the facility on 11/8/24. The medical record did not include documentation to describe why R2 left the facility, where R2 was discharged to or that any assessments were conducted since a weekly skin check conducted on 11/6/24. On 3/11/25 at 2:50 PM, V2 (Director of Nursing) agreed R2's medical record did not include documentation of post fall assessments on 10/7/24; the time R2 returned to the facility on [DATE]; the reason for the Emergency Department (ED) visit or date, time and assessment of R2's return from the ED visit on 10/31/24 and 11/8/24. On 3/12/24 at 10:00 AM, V11 (Licensed Practical Nurse) stated I must have accidentally charted (on R2's Medication Administration Record). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/24 at 12:30 PM, V1 (Administrator) stated documentation in R2's medical record was not accurate and was incomplete. V1 stated the expectation is for staff to have their documentation entered by end of shift.