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	06/27/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident's were free from physical abuse for 2 of 3 residents (R1 and R2) reviewed for Abuse in the sample of 3. The findings include: R1's electronic face sheet accessed on 6/27/25 show R1 has diagnoses that include hemiplegia and hemiparesis affecting right side. Anxiety and delusional disorder. R1's facility assessment dated [DATE] show R1 is alert and able to verbalize his needs. R2's electronic face sheet accessed on 6/27/25 show R2 has diagnoses that include traumatic subdural hemorrhage, drug induced parkinsons, and anxiety disorder. R2's facility assessment dated [DATE] show R2 has no cognitive impairment with BIMS of-15 The Facility Reported Incident (FRI) as final dated 6/10/25 (date of incident as 6/6/25) documents, R1 and R2 were in the dining room at their separate tables. R2 began yelling towards the direction of R1's table. R1 came towards R2 making contact with R2's right forearm. R1 lost his balance fell backwards and hit his head on cooler. Body assessment done with no injuries or complaint of pain. R1 and R2 denied police involvement. R1's MD ordered for R1 to be sent to the hospital for eval. CT scan of head with no evidence of acute intracranial process and cervical spine completed with no acute fractures or dislocation of cervical spine. R1 and R2 feel safe at the facility . On 6/27/25 at 9:30 AM, R1 was alert in his room, R1 stated He (R2) started it, we were both in the dining room, he was mouthing off at me, so I went to him and pushed him, I hit him!. he hit me back then I lost my balance and I fell. On 6/27/25 at 11:30 AM, R2 said regarding the incident on 6/6/25, it was during supper, he came at me saying things to me so I told him to F----ed off!, that's when he hit this arm (contracted right arm) I hit him back. He hit me again, so I hit back until they separated us. He fell , then got up and started hitting me again. Then R2 brought this surveyor to the dining room to show where the incident happened. R2 said he was at table 6 and R1 was in table 12. Table 6 and table 12 were next to each other. Camera's were noted in the dining room. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/25 at 12 PM, this surveyor watched the video surveillance with V1 (Administrator) and V4 (Human Resources.) Video surveillance showed, that both R1 and R2 were in the dining room sitting in their table. R1 got up and walked towards R2. R2 was sitting in his wheelchair in his table. R1 hit R2 numerous times, R2 hit back. R1 fell backwards, V3 (License Practical Nurse-LPN) was now at the scene. R1 got up and again hit R2 while V3 was trying to stop R1. V3 was unable to stop R1 from hitting R2. V4 (Human Resources) and V6 (Cook) were noted to be walking towards R1 and R2. V3 took R2 away in his wheelchair while R1 left the dining room. On 6/27/25 at 10:30 AM, V3 (LPN) said she was the nurse on 6/6/25 when the incident happened. V3 said she was at another table attending to another resident. I turned and I saw R1 approaching R2's table, I yelled, hey stop!, and went towards them. R1 lost his balance and fell backwards hitting his head in the milk cart behind him. R1 got up himself and left the dining room. When a resident hit another resident that is abuse. On 6/27/25 at 10:40 AM, V4 (Human Resources) said on 6/6/25 she was at the facility that evening. It was around suppertime when she heard somebody yelling really loud coming from the dining room hey! stop! V4 said she got up and went to the dining room and saw R1 hit R2's forearm so she hurriedly pulled R2 away from R1. V4 said she called V1 (Administrator) to notify her of the incident. V4 said when a resident hit another resident that is abuse. On 6/27/25 at 10 AM V6 (Cook) said on 6/6/25, he was on break when he heard someone yelling loud coming from the dining room. V6 said he went back to the kitchen then to the dining room. V6 said he saw R1 standing over R2, with R1's hands on R2's chest either pushing R2 or holding R2's shirt. The Nurse (V3) was trying to go in between R1 and R2 yelling stop! stop! Another staff came (V4) and pulled R2 away. V6 said when R1 saw him, R1 stopped and left the dining room probably because he saw another man. V6 said Abuse is when a resident hit another resident. On 6/26/25 at 2PM, V1 (Administrator) said both R1 and R2 have behaviors, there's a company that will be starting soon to come to the facility and provide group therapy to residents with behaviors The Facility on Abuse with a revised date of 1/2019 show, it is the policy of this facility to prohibit and prevent resident abuse neglect exploitation mistreatment and misappropriation of resident property and a crime against a resident in the facility. Physical abuse- hitting, slapping, pinching, kicking, it also include controlling behavior through corporal punishment.