

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145989	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Parker Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident received a diet as ordered, including failure to implement and communicate an ordered diet alternative. This resulted in a significant, unplanned weight loss of 11.1% for 1 of 4 residents (R13) reviewed for significant weight loss in the sample of 17. The findings include: R13's Face Sheet printed on 3/31/26 shows R13 was initially admitted to the facility on [DATE] with diagnoses that include polyneuropathy (damage to nerves in body), major depressive disorder, bipolar disorder, and personal history of transient ischemic attack and cerebral infarction (type of stroke) without residual deficits. The Face Sheet also shows that R13 was readmitted to the facility, following a hospitalization, on 3/11/26 with diagnosis of cerebral infarction. The Face Sheet does not show a diagnosis related to difficulty swallowing. R13's Order Summary Report dated 3/31/26 shows that R13's Dietary order as general diet, pureed texture, thin liquids with allowance for mechanical soft texture upon request. On 3/30/26 at 11:37 AM, during plating of lunch meals, R13's ticket showed double portion/protein, but double portion of protein was not provided. On 3/30/26 at 12:24 PM, R13 was in the dining area and was provided a plate with pureed turkey tetrazzini, dinner roll, blended veggies, cinnamon roll cake, and instant mashed potatoes. R13 only ate the mashed potatoes and stated her dislike of pureed foods and therefore did not eat most meals. R13 stated multiple requests to staff for different foods due to not eating pureed, and that mashed potatoes are provided. On 4/1/26 at 9:26 AM, R13 stated that she was unaware her dietary order showed she can receive a mechanical soft for meals upon request. R13 stated that she has requested an alternate diet to pureed multiple times but is still served pureed. 4/1/26 9:29 AM, V19 (Certified Nursing Assistant-CNA) stated that R13 has a diet order of pureed foods and was aware that R13 was not eating pureed foods but was not aware that R13 could request mechanical soft foods. V19 stated R13 typically consumes only 25% of all meals. On 4/1/26 at 10:06 AM PM, V4 (Dietary Manager) stated that R13's diet order was pureed with no other alternatives. V4 then reviewed R13's medical record and confirmed that R13's diet order was pureed with an allowance for a mechanical soft diet upon request. V4 stated she was aware that R13 does not like pureed and does request different food. On 4/1/26 at 12:37 PM, V20 (Dietician) stated that R13's current diet order was for pureed with the stipulation for allowance of mechanical soft upon request. V20 stated she did not agree with the order due to safety concerns, however, confirmed that she documented R13's diet order for pureed with allowance of mechanical soft in her Dietary Progress Note. V20 confirmed that R13 has weight loss, has an upcoming video swallow evaluation, and has interventions in place that include: ?med pass' supplement (high calorie/high protein) supplement, pureed textured food that R13 will eat can be provided such as the mashed potatoes and double portions, although the double portions are not effective as the resident is not eating pureed food. On 4/1/26 at 12:31 PM, R13 was sitting up in wheelchair outside of dining room. R13 stated she was so happy due to being served real food today; a taco and it was so good, I ate all of it! On 4/1/26 at 1:08 PM, V4 (Dietary Manager) stated that R13 was served a mechanical soft diet for lunch today due to the social worker's request. V4 was informed that R13 consumed 100% of the meal. R13's Weights and Vitals Summary dated 4/1/26 shows the following weights which represent a 15.8lb (pound), 11.1% (continued on next page)</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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F 0692 Level of Harm - Actual harm Residents Affected - Few	unplanned weight loss over approximately six weeks, meeting criteria for significant weight loss:-2/13/26: 141.8lbs-2/20/26: 138lbs-3/4/26: 134.2lbs-3/26/26: 125lbs-3/30/26: 126lbsR13's Nutrition Risk Review dated 3/11/26, printed on 4/1/26, shows that R13 had a weight loss of 5% or more in the last month or loss of 10% more in the last six months and was not on a prescribed weight loss regimen, pureed food intake, has the ability to express ideas and wants and can make decisions regarding tasks of daily life independently, and has no signs or symptoms of possible swallowing disorder.R13's Dietary Progress Note dated 3/28/26, printed on 4/1/26, shows that V4 (Dietary Manager) documented that R13's nutrition is at risk, her diet order is general puree with thin liquids, that R13 may request a mechanical soft diet and a plan to continue diet and supplements as ordered.R13's Care Plan Report printed 4/1/26 does not include a focus area or interventions related to nutrition or weight loss.The facility's Physician Orders-Following Physician Orders (undated) policy shows that it is the policy of the facility to follow the orders of the physician, and the facility will have orders to provide essential care to the resident.		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, interview and record review the facility failed to ensure residents received the correct portion size for the noon meal. This applies to all 63 residents residing in the facility. The findings include: The CMS-671 long-term care facility application for Medicare and Medicaid dated 3/30/26 shows, 63 residents residing in the facility. The facility's menu for 3/30/36 noon meal shows, Turkey Tetrizzini, California blend, dinner roll, cake and beverage of choice. On 3/30/26 at 11:37 AM, V5 (Cook) was plating the noon meal. She used a #6 scoop (2/3 cups/5 1/3 ounce) for the regular turkey tetrizzini (noodles, shredded turkey and sauce) and pureed turkey tetrizzini. The facility's spreadsheet for the noon meal on 3/30/26 shows, regular turkey tetrizzini serving is an 8 ounce spoodle or 2, 4 ounce spoodles, portion size 8 ounces and pureed turkey tetrizzini is 2 #8 scoops (4 ounces/1/2 cup). None of the residents received the correct portion of turkey tetrizzini (mechanical soft was served the same as regular diets). The facility's scoop size color chart shows, a #6 scoop is 5 1/3 ounces and 2/3 cups. On 3/30/26 at 12:49 PM, V5 (Cook) stated, she should have served 2 scoops of the #6 scoop for both (which still wasn't the correct portion size). The facility's accuracy of quality of tray line service (no date) shows, Policy Tray line positions and set up procedures will be planned for efficient and orderly delivery. All meals will be checked for accuracy by the food and nutrition services staff, and by the service staff prior to serving the meal to the individual. Procedure: .6. Each meal will be checked for: .c. Proper portion sizes.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review the facility failed to ensure the dish machine and 3-part sink was sanitizing at the appropriate concentration. This applies to all 63 residents residing in the facility. The findings include: The CMS-671 long-term care facility application for Medicare and Medicaid dated 3/30/26 shows, 63 residents residing in the facility. On 3/30/26 at 9:27 AM, V6 (Dietary Aide) was washing silverware in the dish machine. V5 (Cook) stated, the dish machine was a low temp, chlorine dish machine. V6 tested the dish machine and the test strip did not change colors. She stated, that was ok. On 3/30/26 at 9:40 AM, V4 (Dietary Manager) stated, they just completed maintenance on the dish machine last week. She tested the dish machine again and the test strip changed to a light grey color barely at 50 ppm (parts per million). V4 stated, it should be at 100 ppm. She checked it again just to make sure and the test strip did not change colors that time, it remained white. On 3/30/26 at 11:40 AM, V4 checked the 3-part sink quat sanitizing solution. The test strip showed, the sanitizing solution was at 100 ppm. V4 stated, it needed more solution and should be at 200 ppm. The facility machine washing and sanitizing (low temperature dishwashing machine) policy (no date) shows, Policy: Dishwashing machines will be operated in accordance with manufacturer's instructions. Dishwashing machines may be used for cleaning and sanitizing tableware, utensils, equipment, pots and pans. Procedure: Dishwashing machines using chemicals (typically chlorine) for sanitizing may be used if the temperature of the wash water is not less than 120 F (Fahrenheit), and the temperatures of the rinse water is not less than 75 F, or less than the temperature specified by the machine's manufacturer. The final rinse will have 50 parts per million (ppm) hypochlorite (chlorine) on dish surface. The final rinse will be tested with the appropriate test strip and the results will be recorded on the Low Temperature Dishwashing Machine Log at the beginning of each washing session for breakfast, lunch and dinner. The facility's 3 compartment sinks (no date) shows, Policy: Dishes and cookware will be cleaned and sanitized after each meal. Procedure: .5. Check sanitation sink frequently using a test strip to assure the level of sanitizing solution is appropriate. Follow chemical manufacturer's guidelines to prepare sanitizing solution. The facility's manufacturer's guidelines for quatsan solution for the 3 compartment sink (no date) shows, Food contact surface sanitizing: This product is an EPA registered sanitizer, disinfectant, virucide, mildewstat, cleaner and deodorizer for use in restaurants, bars, institutional kitchens, food handling and process areas. Designed for use on food processing equipment, dairy processing equipment, utensils and other hard, nonporous food contact surfaces in food processing locations, meat plants, bakeries, beverage plants, restaurants and bars. May be used at a variable dilution rate of .75 - 2 oz. (ounce) per 4 gallons of water (or equivalent use dilution), which yields 150-400 ppm active quat.</p>		

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on interview and record review the facility failed to have a system in place to verify Certified Nursing Assistants (CNAs) have received the required 12 hours training yearly. This applies to all 63 residents residing in the facility. The findings include: The CMS form 671 dated 3/30/26 showed there were 63 residents residing at the facility. On 4/1/26 at 10:00 AM, this surveyor requested training files for V8, V9, V14-V16, (all Certified Nursing Assistants-CNAs.) The facility was not able to provide documentation verifying that these CNAs received the required 12 hours of annual Inservice training. There was also a sign posted by the time clock dated 11/19/25 for CNAs that included V8 and V9 to complete their required training. On 4/1/26 at 10:20 AM, V8, V9 and V14 all CNAs said they received in-services from the facility but were not sure if they had met the required trainings yet. On 4/1/26 at 10:45 AM, V1 (Administrator) said the facility is in the process of implementing a system to track CNA training hours to ensure completion of the required 12 hours of annual training. The Facility Policy entitled Guidelines for Education in the Facility documents, CNAs must complete 12 hours of in-service training annually, that include: a) dementia management, b) resident abuse protection, c) training that addresses any area of weakness or potential weakness by the individual, d) training needed to carry any special needs resident within the facility's population. There must be a process in place to track staff participation in trainings.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review the facility failed to ensure as needed (PRN) psychotropic medications had a stop date for 4 of 5 residents (R4, R24, R9 and R49) reviewed for psychotropic medications in the sample of 17. The findings include:</p> <ol style="list-style-type: none"> 1. R4's Physician Order sheet (POS) shows an order dated 3/21/26 for alprazolam 0.5 milligram (mg) per peg tube every 8 hours as needed for anxiety, with no stop date. R4's POS also shows an order dated 3/29/26 for Ativan 0.5 milliliters (ml) 2mg/ml every 2 hours as needed for anxiety and 0.5 ml by mouth every 6 hours for agitation and restlessness, with no stop date. 2. R24's POS shows and order dated 3/4/26 for Ativan Oral Tablet 1 mg, give 1 tablet by mouth every 6 hours as needed for restlessness, with no stop date. <p>On 4/1/26 at 10:30 AM, V2 (Director of Nursing) said she was in charge of the psychotropic meds making sure as needed psychotropic meds have stop dates of 14 days. If the medication needs to be longer than 14 days, the physician should be informed to evaluate the need for the medication.</p> <ol style="list-style-type: none"> 3. R9's Physician Order Summary shows active orders for lorazepam 1 mg (psychotropic medication/ anti-anxiety), give 1 tablet by mouth every 4 hours as needed for restlessness effective 12/29/2025, and for olanzapine 10 mg (psychotropic medication/ anti-psychotic) inject 5 mg intramuscularly every 8 hours as needed for agitation effective 1/14/2026. There is no stop date for either of the medications. <p>R9's Medication Administration Record (MAR) shows R9 received lorazepam on March 5, 10, 11, and 2 doses on March 19.</p> <p>R9's Electronic Medical Record (EMR) failed to show documented assessments and new orders every 14 days for psychotropic/anti-psychotic medication.</p> <ol style="list-style-type: none"> 4. R49's Physician Order Summary shows active orders for olanzapine 5 mg intramuscularly every 8 hours as needed for anxiety/agitation effective 8/6/25. There is no stop date for the medication. <p>R49's EMR failed to show documented assessments and new orders every 14 days for psychotropic/anti-psychotic medication.</p> <p>The facility provided Psychotropic Drug Usage policy (undated) states, Residents receiving psychotropic medications will have gradual dose reductions and behavioral interventions implemented unless contraindicated. Residents who receive PRN (as needed) psychotropic medications will be evaluated if the medication is extended longer than 14 days and the rational will be documented in the resident's medical record. In the event the medication is an anti-psychotic the prescribing practitioner will assess the resident for a continued need.</p>		

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<p>F 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to treat a resident with dignity and respect for 1 of 17 residents (R4) reviewed for dignity in the sample of 17. The findings include: On 3/30/2026 at 10:55 AM, during family interview, V13 (R4's POA and daughter) said R4's (on hospice) family were all here at the facility due to R4 transitioning (actively declining towards end of life). V13 said there was an incident over the weekend that R4's nurse refused for R4 to get up even when R4 was wanting to get up. V13 said the nurse (V11- License Practical Nurse-LPN) ignored the request. V13 stated these are my mom's last days, and if she wanted to get up, she should be gotten up V13 said V11 (LPN) was arguing with her, and she was sure R4 heard all that. V13 stated ?this was reported to the DON (Director of Nursing V2). On 3/30/26 at 12 PM, V12 (License Practical Nurse-LPN) said she was at the facility last Friday (3/27/26) and witnessed V13 and V11 (LPN) arguing regarding R4 getting up, this was done by R4's room, the argument can be heard through the hallways and nurse's station. V12 said R4 who is on hospice had been wanting to get up lately, they should have just gotten R4 up. On 3/31/26 at 12:27 PM said V11 (LPN) said she thought R4 was not supposed to be up per V2's direction. V11 confirmed this made R4's family upset. On 3/31/26 at 2PM, V2 (Director of Nursing) said staff should have honored the resident's and family's requests and ensured they were treated with respect. The facility policy entitled Dignity (undated) shows that staff will always be polite and respectful. Staff will not speak in a manner that that could be interpreted as a minimally condescending/critical or argumentative.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview and record review the facility failed to ensure a resident was supervised during medication administration for 1 of 17 residents (R20) reviewed for Pharmacy Services in the sample of 17. The findings include: On 3/30/26 at 9:33 AM R20 was in her room lying in bed, next to her on her bedside table were 2 clear medication cups with pills inside. One cup had a large white pill, and the second cup had 7 pills inside including 2 large white pills, 1 pink pill, 1 green pill, 1 blue pill and 2 small white pills. R20 said Sometimes they leave the pills in here for me to just take and sometimes they don't, it depends on who the nurse is. On 3/31/26 at 8:51 AM, V3 (Assistant Director of Nursing) said, medications should not be left at a resident beside nurses should observe the resident take the medication. There are no residents who have orders that they can self-administer medications and R20 should have been supervised while she took her medication. R20's Medication Administration Record (MAR) shows she takes the following oral medications at 8:00 AM: Acidophilus 100 Milligrams (MG.), Amlodipine 5 MG., Levothyroxine 150 Micrograms (MCG.), Lisinopril 5 MG., Omega 3 1000 MG., Toprol XL 25 MG., Glyburide 5 MG., Metformin HCL 500 MG., and Dicyclomine HCL, 20 MG. R20's Physician Order Summary does not show any order to self-administer medications. The facility provided not dated Medication Administration policy shows that nurses should remain with the resident during medication administration.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review the facility failed to administer medications as ordered. There were 33 opportunities with 2 errors resulting in a 6.06% error rate. This applies to 1 of 2 residents (R37) observed during medication pass. The findings include: On 3/31/26, V3 (Assistant Director of Nursing) was continuously observed completing medication pass from 8:33 AM to 9:00 AM. On 3/31/26 at 8:33 AM, V3 administered medication to R37. Two (2) medications were not administered, Allopurinol and Benzotropine. V3 said the medications were not in the cart and she had to reorder them from the pharmacy. V3 said these medications are not in the facility on site medication supply. R37's Physician Order Summary shows active orders for R37 to receive Allopurinol 100 MG (Milligrams) give 2 tablets daily for gout and for Benzotropine Mesylate 1 MG two times a day. R37's Medication Administration Summary shows R37 should receive the Allopurinol at 8:00 AM, and Benzotropine at 8:00 AM and 8:00 PM. The facility provided not dated Medication Administration policy shows medication should be administered as ordered to help residents overcome illness and to relieve and prevent symptoms.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to carry out a physician order as prescribed and failed to increase a residents antipsychotic medication contributing to a significant medication error. This failure resulted in a R10 missing 48 doses of the medication increase. This applies to 1 of 5 residents (R10) reviewed for unnecessary medications in the sample of 17. The findings include:R10's face sheet shows she has the following diagnoses: Schizoaffective Disorder Bipolar type, unspecified dementia and post- traumatic stress disorder.R10's current care plan initiated [DATE] shows she has a serious and persistent mental illness and requires the use of psychotropic medication to help manage anxiety, neurosis and insomnia and staff should carry out the medication management regimen as prescribed. R10's care plan also shows she requires strategies to deal with hallucinations and delusions. A Physician Progress Note completed by V18 (Nurse Practitioner) on [DATE] shows that R10 reported having auditory and visual hallucinations of deceased people causing her distress. R10 also told V18 that these hallucinations have occurred recently despite the current medication regimen. V18's progress note for R10 shows she increased the Latuda (antipsychotic medication) from 20 Milligrams (MG.) to 40 MG. in the morning and continue with 80 MG in the evening to help alleviate her psychotic symptoms. R10's Physicians Order Summary (POS) shows an order effective [DATE] for Latuda 20 MG. daily and Latuda 80 mg. also daily. R10's Medication Administration Summary (MAR) shows In Feb. and [DATE] the Latuda doses that R10 received were Latuda 20 MG. at 8 AM and 80 Mg. also was given at 8 AM not 8 PM as ordered. The 40 MG. dose increase was also not carried out onto the POS or MAR. R10's POS also shows she does not have any PRN (as needed) medication ordered to be given if she was having increased hallucination symptoms. On [DATE] at 10:46 AM, V2 (Director of Nursing) said unfortunately this order was missed and the Nurse Practitioners were writing orders on paper and giving them to the nurses. V2 said the orders should be carried out when received by the physicians and she is the person responsible for reviewing the Physician Progress notes when they receive them to be sure everything is followed. On [DATE] at 1:35 PM, V18 said I am not surprised they missed the orders they didn't do alot of things there. I ordered the medication for R10 because she was having auditory and visual hallucinations despite being on the current Latuda dose, so I increased the medication to try to eliminate those. The negative outcome of this would be unfortunately it would not lessen her symptoms and she would still have the hallucinations.The facility provided not dated Physician Orders policy states, It is the policy of the facility to follow orders of the physician. ?As assessments are completed, orders will be received from the physician to address significant findings of the assessments.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that staff performed proper hand hygiene after removing gloves during wound care to prevent cross contamination for 1 of 17 residents (R2) reviewed for infection control in the sample of 17. The findings include: R2's Face Sheet printed on 4/1/26 shows R2 was admitted to the facility on [DATE] with diagnoses that included other specified local infections of the skin and subcutaneous tissue and pressure ulcer of sacral region, stage 4. R2's Order Summary Report dated 4/1/26 showed R2 requires wound care every dayshift and as needed and enhanced barrier precautions related to R2 having wounds. On 4/1/26 at 11:08 AM, an Enhanced Barrier Precaution (EBP) sign on R2's door showed staff must clean their hands and wear gloves and gown for high-contact resident care activities that included wound care. V3 (Assistant Director of Nursing-ADON) and V14 (Certified Nursing Assistant-CNA) performed hand hygiene with hand sanitizer (waterless alcohol-based agent), donned gloves and gowns and entered the room to perform wound care. V3 and V14 positioned R2 on R2's left side. V3 and V14 then removed their gloves and donned new gloves, but no hand hygiene was performed. V3 prepared the supplies and dressing needed for wound care. V3 then removed the dressing from R2's sacrum and coccyx area, which was saturated with yellowish brown drainage. V3 then removed gloves and donned new gloves without performing hand hygiene. V3 cleansed the wound, removed and donned new gloves, but no hand hygiene was performed. V3 applied a new dressing to the wound and performed additional cleansing to buttocks with application of barrier cream, then removed and donned new gloves did not perform hand hygiene. R2 was repositioned in bed. V3 then removed gloves but did not perform hand hygiene. Directly after exiting R2's room, V3 stated she would usually bring in hand sanitizer but forgot it on the wound cart outside of R2's room. V3 stated that hand hygiene is to be performed after each removal of gloves, prior to donning new gloves and hand sanitizer may be used unless hands are visibly soiled in which hands would then be washed. The facility's Infection Control: Hand Hygiene Guideline (undated) showed that the scope of the guideline includes all individuals that partake in the resident plan of care are to perform hand hygiene, wash or sanitizer, allowing hands to completely dry prior to applying gloves or interacting with a resident.</p>		