STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007371	A. BUILDING: _____ B. WING _____	C 12/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSON PARK HEALTH CARE CTR	6141 NORTH PULASKI ROAD CHICAGO, IL 60646

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: -1686599/IL89939 -1686992/IL90350 -1687146/IL90521-F323 cited Incident Investigation of 12.05.2016/IL90408-F323 cited	S 000		
S9999	Final Observations Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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 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.	S9999	Attachment A Statement of Licensure Violation	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/06/17

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidence by: Based on interview and record review the facility failed to implement appropriate interventions during ADSL (Activities of Daily Living) for two of three residents (R4, R5) reviewed for injury. These failures resulted in R4 sustaining a head injury, cut on face and fractured clavicle (collar bone) and R5 sustaining tibia/fibula fractures (leg). Findings include: Review of the facility's incident report of 12.5.16 notes in part, (R4) continues to display impaired functional capacity, requiring total assistance x2 person in all ADLs/mobility. (R4) can be very resistive to care making it difficult for the staff to provide care for (R3). (R4) has behavior(s) by(of) kicking, pushing things near (R4), grabbing (and) not letting go. At the time of the incident during care resident grabbed the side rail and did not let it go, side rail went loose and resident fell out (of) bed. Resident was sent out (to the hospital) for further evaluation. Post incident diagnosis(es): head injury, cut on face and closed nondisplaced fracture of right clavicle. Review of facility's "Post Incident Investigation" notes in part: "II. Analysis of Data and Cause of Incident: Resident (R4) needs 2 person assist for ADL transfer." Review of R4's medical record (Face Sheet) notes in part R3 has the following diagnoses including but not limited to: Hemiplegia and	S9999		

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S9999	Continued From page 2 hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Hypertensive heart disease, Major depressive disorder, Unspecified psychosis, Unspecified dementia and Behavioral disturbance. R4's most recent RAI (Resident Assessment Instrument) prior to incident of 12.5.16, dated 10.17.16) notes in part, R4 requires extensive assistance of two plus persons assist in the area of toilet use (including but not limited to how resident cleanses self after elimination). Care plans (bed mobility revised 12.1.15; ADL self care performance deficit initiated 10.21.16 and at risk for falls revised 9.7.16) note under interventions, R4 requires extensive two staff physical participation to reposition/turn in bed/use toilet and for falls, "floor mat provided". E5 (CNA-Certified Nursing Assistant, 12.21.16 at 5:47 PM) said in part, while rendering incontinence care to R4 (on 12.5.16), E5 was moving from the left side of R4's bed to the right (after first positioning R4 on his right side) when R4 grabbed the left side rail with his right hand and began shaking the side rail. The side rail "went loose" and R4 fell to the floor. E5 said the bed was raised to a comfortable height for her to provide care to R4; she was alone in R4's room while performing incontinence care; floor mats were in place prior to but not during the time E5 rendered incontinence care to R4. E5 said she would only ask for help when transferring R4 from bed or when moving resident up in bed. E2 (DON-Director of Nursing, 12.22.16 at 12:19 PM) said in part, R4 is a two person assist with all ADLs. E5 did not seek the assistance of additional staff in order to safely render incontinence care to R4.	S9999		

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S9999	Continued From page 3 Review of facility's incident report of 12.15.16 notes in part, (R5) claims she was asked by CNA to stand and pivot for transfer at the time of incident. At 8 am, R5 complained of pain to the right lower extremity. Due/scheduled Morphine sulfate was given. At 9 am R5 still with complaint of pain, PRN (as needed) medications given. R5 was referred to the Nurse Practitioner with order of right hip and lower extremity(ies) x-ray. X-ray report shows nondisplaced fracture involves the mid tibial (tibia) and fibula. Resident attending (physician) aware of x-ray result with order to sen to ER (Emergency Room) for evaluation and treatment. Review of R5's medical record (Face Sheet) notes in part diagnoses including but not limited to: Hypertensive heart disease, Major depressive disorder, Rheumatoid arthritis and Chronic pain. Progress Note of 12.19.16 notes in part, R5 was readmitted to the facility with the admitting diagnosis of non-displaced comminuted (broken or crushed into small pieces) right fibula fracture. (R5) requires extensive, two staff physical assistance during transfers. (R5) requires a (mechanical) lift during transfers. R5's most recent RAI (dated 11.3.16) prior to the incident of 12.15.16 indicates R5 requires extensive assistance of two plus persons assist during transfers. Care plan (ADL Self Care Performance Deficit, initiated 11.7.16) notes under interventions, (R5) requires extensive two staff physical assistance with transfers. R5 (12.23.16 at 4:25 PM regarding incident of 12.15.16) said in part, per translation assistance provided by E10, he (black male) came into my room around 5 am. It was the first time he took	S9999		

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S9999	Continued From page 4 care of me. He stood me up. He told me to grab the side rail, then tried to stand me up. I didn't stand. Then he put me in the (recliner) chair. That's when I got hurt, when he tried to make me stand. Z1 (Former employee, 12.23.16 at 12:55 PM regarding incident of 12.15.16) said in part, he asked a colleague to assist to transfer R5 from bed to (recliner) chair. He said he waited for assistance for 10 minutes then transferred R5 from bed to (recliner) chair by sliding R5. Z1 also said this was the first time he took care of R5. E9 (CNA, 12.23.16 at 1:32 PM regarding incident of 12.15.16) said in part, R5 requires a (mechanical) lift with two person assist for transfers. E6 (Assistant Director of Nursing, 12.23.16 at 12:42 PM) said in part, Z1 transferred R5 from bed to (recliner) chair by himself; R5 is a two person assist for transfers. Z1 did not seek the assistance of additional staff in order to safely transfer R5 from bed to chair. (B)	S9999		