STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145989	B. WIN	IG		03/0	C 08/2012
	PROVIDER OR SUPPLIER	CENTER	•	516	ET ADDRESS, CITY, STATE, ZIP CODE S WEST FRECH STREET REATOR, IL 61364		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	she tipped over in against the van gar says her shoulder times. R2 says she happened and that in. On 2/29/12 at 10:0 Service Director) s R2 incorrectly. E8 in the back of the wwrong spot. E8 and strap is to be used	age 5 her wheelchair and landed te with her right shoulder. R2 is not broken but does hurt at e does not know how it she thought she was strapped O A.M. E8 (Environmental tated that E4 had strapped in said that one of the two straps wheelchair was hooked in the d E4 both stated that only one in the front of the wheelchair. or use of the restraint system"	F	323			
F9999	the front of the who FINAL OBSERVAT Licensure Violation 300.1210b)5) 300.1210d)6) 300.3240a)		F99	999			
	b) The facility shall and services to attain practicable physical well-being of the reeach resident's corplan. Adequate and care and personal resident to meet the						

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		145989	B. WII				C 8/2012
	NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER			5	REET ADDRESS, CITY, STATE, ZIP CODE 16 WEST FRECH STREET STREATOR, IL 61364	1 00/0	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETION DATE
F9999	shall include, at a magnetic procedures: 5) All nursing personencourage resident transfer activities as effort to help them in practicable level of d) Pursuant to subscare shall include, and shall be practic seven-day-a-week 6) All necessary preassure that the resides free of accident nursing personnels that each resident mand assistance to proceed as free of accident nursing personnels that each resident mand assistance to proceed as free of accident from the section 300.3240 Ara and assistance to proceed as free of accident from the section and assistance to proceed as free of accident from the section and assistance to proceed as free of accident from the section and assistance to proceed as free of accident from the section and the sect	ninimum, the following nnel shall assist and s with ambulation and safe s often as necessary in an retain or maintain their highest functioning. section (a), general nursing at a minimum, the following sed on a 24-hour, basis: ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision wrevent accidents. Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a	F9	999			

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		145989	B. WING			C 03/08/2012	
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER			•	5	REET ADDRESS, CITY, STATE, ZIP CODE 16 WEST FRECH STREET TREATOR, IL 61364		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	1. R3's most recent 12/05/11 notes R3 to for bed mobility, trapersonal hygiene, a Facility Incident/Aconotes that the E9 (Falled to R3's room was found to have, protrusion noted." N 1:45 P.M. read, "Su (Certified Nurse's Abe swollen with harfemur." On 2/29/12 at 9:40 was called down to approximately 1:45 noted to have what pushing out against called E2 (Director to help assess. R3 hospital for evaluatinot know how R3 s Local hospital Histo 2/16/12 notes that Federomity." "The pa Emergency Room a and angulated fract the right femur." Out of the area hos dated 2/27/12 notes transferred to anoth her right hip. This s notes that on 2/20/7	Minimum Data Set dated to be total dependent on staff nsfers in/out of bed, dressing,	F99	9999			

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		145989	B. WI	NG _			C 8/2012	
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER				5	REET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET STREATOR, IL 61364	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	stated that the type sustained could not routine cares like to and dressing. Z1 s "blunt force" to cause On 2/24/12 at 11:00 she had taken care found the swollen rithat R3 had not conhad no idea how R3 fracture. On 2/24/12 at 11:50 she and E3 had taken until R3's fractured E4 stated that R3 h that day and that R3 her legs like she us did not seem as if s E4 does not know if femur fracture. On 2/29/12 at 10:33 stated that she had with R3 and that E5 sustained the right. On 3/1/12 at 2:00 P that she and E7 (CI morning of 2/16/12 different regarding)	a.M. Z1 (Orthopedic Surgeon) of femur fracture R3 have happened during urning, positioning, transfers aid that there had to be some se that type of break. A.M. E3 (CNA) stated that of R3 from 6 A.M. until they ght leg at 1:45 P.M. E3 stated inplained of pain and that she is sustained that right femur A.M. E4 (CNA) stated that en care of R3 from 6 A.M. leg was noted at 1:45 P.M. ad been acting more lethargic is was not bearing weight on ually would. E4 stated that R3 she was in any pain and that now R3 sustained the right	F99	999				

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		145989	B. WIN				C 8/2012
	NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER			5	REET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET STREATOR, IL 61364		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	OULD BE	(X5) COMPLETION DATE
F9999	that she and E6 had of 2/16/12 and that to R3 leg. E7 stated R3 sustained the fra 2. Incident/Accident that between 1:30 F "Wheelchair toppled On 2/24/12 at 11:50 2/9/12 when she was facility van to an ap the wheelchair whe E4 stated that R2 d fell against the elect that management h E4 had placed the stated that R2 d says her shoulder is times. R2 says she happened and that in. On 2/29/12 at 10:00 Service Director) st R2 incorrectly. E8 s in the back of the w wrong spot. E8 and strap is to be used in the van notes the state of the van notes the va	ge 9 .M. E7 (3rd shift CNA) stated dressed R3 on the morning they did not notice any injuries I that she does not know how acture to her right femur. Report dated 2/9/12 notes P.M. and 2:00 P.M. R2's dover while in the van." A.M. E4 (CNA) stated that on as transporting R2 in the pointment, R2 tipped over in a E4 was turning the corner. Id not tip all the way over, but tric gate in the van. E4 stated ad said after the incident that safety straps on incorrectly. P.M. R2 stated that on 2/9/12 her wheelchair and landed the with her right shoulder. R2 is not broken but does hurt at does not know how it she thought she was strapped on A.M. E8 (Environmental ated that E4 had strapped in aid that one of the two straps heelchair was hooked in the E4 both stated that only one in the front of the wheelchair. The use of the restraint system at there is to be two straps in elchair as well as the back. (B)	F99	999			

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AND I DAY OF GOTHLOTTON			A. BUILDING		C	
		145989	B. WING		03/08/2012	
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET		
				STREATOR, IL 61364		
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