(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)			R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING:		С			
		IL60073	371			5/2025			
NAME OF F	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 STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE		
S 000	Initial Comments			S 000					
	Complaint Investigation: 2581781/IL187420								
S9999	9 Final Observations			S9999					
	Statement of Licensure Violations: 300.3210t)								
	Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.								
	This REQUIREMENT is not met as evidenced by:								
	Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident. This failure affected 1 (R2) resident who vocalized that he felt his life was in terrible danger when a resident (R5) slapped him on his face.								
	Findings include:								
	On 03/17/2025 at 1 weeks ago, we (R2 car insurance, when open right hand abound to do. When he felt I was in a terrible	and R8) were n he (R5) slap ove my templois nis hand lande	e talking about oped me with his e. I did not know						
	On 03/17/2025 at 1 observed (R5) hittir He (R5) hit him (R2 him (R2), and he (R5) open hand on the le (R5) said he was up	ng (R2) a cou c) on the face R5) hit him on eft side of his	ple of weeks ago. I was talking to his face with (R2) face. He						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/03/25 **Electronically Signed** 

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		C		
	IL6007371 B. WING		B. WING		03/25/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PETERS	ON PARK HEALTH C	ARF CTR	TH PULASK , IL 60646	(I ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	nge 1	S9999			
	talking to me. The	intent was to physically harm old you I don't want you in my				
	room."  On 03/19/2025 at 2:21pm, V22 (Licensed Practice Nurse) stated I was working that weekend on 03/01/2025. I was by my cart outside of the room preparing (R8)'s medications, while doing that, I heard a strange sound. I went in the room to see what is going on. I saw (R5) and (R2) standing up. (R2) was panting. He was upset based on his body language. There was a frown on their faces. I went in the middle. I sat him (R2) on his wheelchair and propelled him to his room. I asked him what happened, and he (R2) said R5 hit me on my face. I went to (R5)'s room and asked him what happened, and he (R5) said I told him not to come to my room while I am sleeping; he just kept on coming and so I just let him know how serious I am about not coming to my room while I am resting. I did assess him (R2). He has redness on the side of his face, I don't remember which side. It was tender because when I touched it, he moved his face away not wanting to be touched. He did a reaction of pulling his face away when I touched that side of his face.					
	Practitioner) stated (R2). From what I valtercation betweer got punched on his him and there was	2:49am, V18 (Family Nurse I was called to assess him was told, there was an n (R2) and (R5) that he (R2) left side of face. I assessed tenderness on that side of his o discoloration, but it was				
	Director) stated (Rs	3:28pm, V11 (Social Service 5) slapping (R2) is considered s not expected of resident to her resident. Our environment				

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STATE FORM 6899 GJKX11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED  C 03/25/2025		
	IL6007371			B. WING			
	PROVIDER OR SUPPLIER  ON PARK HEALTH CA	ARE CTR	6141 NOF	DRESS, CITY, S RTH PULASK D, IL 60646	TATE, ZIP CODE I ROAD		
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From particles should be a home I all the residents.  On 03/17/2025 at 2 stated I asked him (R5) said R2 kept or room. He (R5) said deprived and frustrasleep, and he said course, a resident in by another resident himself and he made could not think becared and sease, and hypoted rectosigmoid junction disease, and hypoted R2's (02/06/2025) Mocumented, in part Patterns. C0500. B Status) Summary Report of the interview. C100 decision making: 1 some difficulty in new M2's (Active Order Summary Report of hospital ER for heaphysical altercation R2's (3/6/2025) After in part "Today's vision R2's (03/07/2025) findividual name in the lost control over	ike environment and ike en	strator) dent. He 5 and R8) eep ould not the face. Of ee slapped vas just not He really deprive. hat R2's neoplasm of heart  or omplete for daily dence -  Order "send to due to 5."  cumented, Battery."  umented, in . Cross iew with stated that				

Illinois Department of Public Health

STATE FORM 6899 GJKX11 If continuation sheet 3 of 5

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	(X3) DATE SURVEY COMPLETED					
IL6007371 B. WING	C <b>03/25/2025</b>					
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6141 NORTH PULASKI ROAD  CHICAGO, IL 60646						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	D BE COMPLETE					
S9999  Continued From page 3  and due to (R2)'s laughing at his request to keep it down. (R5) stated he never intended to just get his attention. Summary of Interview with residents on the unit: (R8) stated that he saw (R5) slap (R2)'s face as a means to get him to leave.  Summary of investigator's findings: (R5) said he slapped (R2) as a way of telling him to leave the room. (R5) explained that he was extremely tired and 'lost himself a bit', believing it was the only way to achieve peace and quiet. Based on resident and staff interviews, the allegation of abuse cannot be substantiated. (R5) believed that slapping (R2) was the only way to create a quiet atmosphere and remove (R2) from his room. He stated that he 'lost himself' momentarily."  R5's Admission Record documented that R5's diagnoses (include but not limited to) hypertension, osteoarthritis and Type 2 Diabetes Mellitus. Date of Discharge: 03/01/2025. Discharged to: Acute Care Hospital.  R5's (01/23/2025) Minimum Data Set documented, in part "Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15." Indicating R5's mental status as cognitively intact.  R5's (09/05/2024) care plan documented, in part "Focus: Identified Offender - history of criminal behavior. Aggravated battery. Goal: will behave in a safe manner consistent with resident conduct policies.  R8's Admission Record documented that R8's diagnoses (include but not limited to) essential hypertension, alcohol abuse and dependence and anxiety disorder.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED				
II 6007374		B. WING		C				
		IL6007371	b. WING		03/2	25/2025		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PETERS	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE		
S9999	documented, in par Patterns. C0500. B Status) Summary Smental status as mental status as me	t "Section C. Cognitive IMS (Brief Interview for Mental Score: 10." Indicating R8's oderately impaired.  dents' Rights for People in acilities documented, in part e resident in the State, you tain rights, protections and g to State and Federal laws. y. You must not be abused		DEFICIENCY)				

6899

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