

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S0000 S9999	Initial Comments Complaint Investigation: 2524682/IL193092 Final Observations Statement Of Licensure Violation: 300.610a) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and	S0000 S9999		

Office of Primary Care and Health Systems Management

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

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 1</p> <p>provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable</p> <p>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</p> <p>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</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>These regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to identify and investigate an allegation of sexual abuse for two residents (R1 and R3); and failed to protect (R1 and R3) from any further possible alleged sexual abuse. These failures led to R1 and R3 to withdraw from socialization and daily activities. R1 and R3 remained in their rooms to avoid contact with the alleged perpetrator (R2).</p> <p>Findings Include:</p> <p>The Facility's "Abuse Prevention Program," dated 01/2019, documents "This facility will not tolerate resident abuse or mistreatment or crimes against a resident by anyone, including staff members, other residents, consultants, volunteers, and staff of other agencies, family members, legal guardians, friends, or other individuals. This policy will define how the investigation of abuse allegations and mistreatment or</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 2</p> <p>crimes will be conducted and outline the process of reporting, investigating, and arriving at a conclusion or disposition of the allegation."</p> <p>The Facility's "Abuse Prevention Program," dated 01/2019, documents "Sexual abuse: Including, but not limited to, sexual harassment, sexual coercion, or sexual assault."</p> <p>The Facility's "Abuse Prevention Program," dated 01/2019, documents "Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment, or a crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to the DON (Director of Nursing). Any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of resident property, mistreatment or a crime against a resident is reported to covered individual, covered individuals are notified annually of these reporting requirements. All resident, visitors, volunteers, family members, or others are encouraged to report their concerns or suspected incidents of potential abuse, neglect, exploitation, or mistreatment to the Administrator or an immediate supervisor who immediately reports the allegation to the Administrator."</p> <p>The Facility's "Abuse Prevention Program," dated 01/2019, documents "All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or a crime against a resident will be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or a crime against a resident will result in an abuse investigation. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, approaches, and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility."</p> <p>R1's Medical Record documents she was admitted to the</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 3</p> <p>facility on 2/5/25 with diagnoses to include but limited to "Anxiety, Paranoid Schizophrenia and Auditory Hallucinations."</p> <p>R1's MDS (Minimum Data Set) Assessment, dated 5/13/25, documents R1 BIMS (Brief Interview for Mental Status) indicates a score of 14 out of possible 15; indicating R1 is cognitively intact. R1's MDS documents that R1 had no hallucinations or delusions. R1's MDS documents R1 did not have any physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, or any other behavioral symptoms not directed towards others.</p> <p>R3's Medical Record documents she was admitted to the facility on 2/5/2025 with diagnoses to include but not limited to "Epilepsy, Major Depressive Disorder recurrent severe with psychotic symptoms, Schizoaffective Disorder depressive type, Moderate Intellectual Disabilities and Delirium due to known physiological condition, Auditory Hallucinations, and Post-Traumatic Stress Disorder."</p> <p>R3's MDS (Minimum Data Set) Assessment, dated 5/13/25, documents R3's BIMS (Brief Interview for Mental Status) indicates a score of 15 out of possible 15, indicating R3 is cognitively intact. R3's MDS documents that R3 had no hallucinations or delusions. R3's MDS documents R3 did not have any physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, or any other behavioral symptoms not directed towards others.</p> <p>R3's current Care plan, dated 2/18/25, documents "(R3)'s history indicates that she has experienced significant trauma during her lifetime and is a trauma survivor. She reports a history of sexual assault/sexual violence as well as the death of her husband. Reinforce with the caregiving team that trauma refers to experiences that cause intense physical and psychological stress reactions."</p> <p>On 5/27/25 at 1:30 PM, R1 stated "(On 5/26/25, R2) told me that we (R1 and R3) could masturbate while he masturbates. (R2) also told me to get online and buy a dildo so he can keep me happy with it. We told (V5 Activities Aide) that (R2) was scaring us and saying sexual stuff to us. She (V5/Activity Aide) told us to tell management when they came in on Tuesday. We (R1</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 4 and R3) told (V5) that we were scared of (R2) and that we were staying in our room so he couldn't get to us. He has said kind of inappropriate things to us since we have gotten here but he got really bad over the weekend."</p> <p>On 5/27/25 at 1:30 PM, R3 stated "(R2) scares me. He said he wants to have sex with me. I have been abused and raped in the past and do not want that to happen again." R3 was tearful and visibly agitated. "I don't have to listen to someone talk to me like that, I loved my husband, he is dead now, that does not mean I am available for sex. I told (R2) I just wanted to be friends with him, but he kept trying to tell me that I should want to have sex with him." R3 stated R2 was saying inappropriate things "on and off" all weekend.</p> <p>On 5/27/25 at 1:30 PM, R4 stated that R1 and R3 complained to her about R2 "saying sex stuff" on Monday 5/26/25, and R4 stated she "took them (R1 and R3) to (V5/Activity Aide) and told them to tell her so they did not have to hide in their room. (V5) told us there was nothing she could do and that we should tell management in the morning. (V5) told me (R4) that I needed to quit stirring up trouble."</p> <p>On 5/27/25 at 2:00 PM, V5 (Activity Aide) confirmed that R1, R3 and another resident (R4) came to her on 5/26/25 at an unknown time and told her that (R2) was saying sexually inappropriate things to them. V5 stated "I don't even know what all he supposedly said." V5 stated that R3 told her that she (R3) was scared and was staying in her room to avoid (R2). V5 stated "I told her that was a good idea, and she (R3) should just leave him alone. There was no management staff in the facility because it was Memorial Day. What was I going to do? I am not management in the building. They need to tell management or the charge nurse. I did not know who to call, that is why I told them (R1, R3 and R4) to report it the next day." V5 confirmed that she did not alert anyone else of the complaint, nor did V5 talk to any staff members or other residents regarding the allegation. V5 stated "(R4) likes to spread rumors, she likes to keep those two (R1 and R3) worked up." V5 was unable to give any examples of what rumors R4 had spread or any disturbance that R4 had caused in the facility. V5 stated "I don't know, she is always listening getting into other people's business."</p> <p>R4's Medical Record documents that she was admitted on</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 5 1/9/2025 with diagnoses to include but not limited to "Cerebral Infarct, Major Depression, and Insomnia."</p> <p>R4's MDS (Minimum Data Set) Assessment, dated 4/16/25, documents R4's BIMS score of 15 out of 15, indicating R4 is cognitively intact. R4's MDS documents R4 had no hallucinations or delusions. R4's MDS documents R4 had no physical behavioral symptoms directed towards others, verbal behavioral symptoms directed toward others, or other behavioral symptoms not directed towards others.</p> <p>On 5/27/25 at 1:30 PM, R1 stated, "(R3) has been very upset and hiding in our room. Everyone (staff) seems to think that (R4) has told us to try to get (R2) in trouble and she has not. (R3) has a long history of abuse and rape so I believe she is triggered at this point. (R2) should not be allowed to say things like that to any women. They (V1 Administrator) and (V4 Social Services Director) told us that we always have the right to walk away from conversations that we don't want to be a part of. I told them we (R1 and R3) are scared, that they need to make him (R2) behave, not us. We told (V17/Certified Nurse Aide) and she seemed to be the only one who actually cared."</p> <p>On 5/27/25 at 2:15 PM, V7 (Certified Nurse Aide/CNA) confirmed that R1, R2, R3, and R4 all currently reside on the same hallway in the facility.</p> <p>On 5/27/25 at 1:00 PM, V1 (Administrator) provided all abuse allegations investigated by the facility in the past three months. There was no investigation regarding R1 and R3's allegation of sexual abuse by R2 from 5/26/25. V1 did provide a "Concerns/Compliments/Questions/Suggestions" form dated 5/28/25 signed by V4 (Social Services Director) that documents (R3) reported to writer that (R2) was talking about sex to her." The form documents "Response/Resolution: discussed with (R3) about walking away from conversations she does not want to be part of."</p> <p>On 5/27/25 at 2:45 PM, V4 (Social Services Director) stated she had received the written statements left under management personnel's door when she (V4) arrived at work at approximately 8:30 AM - 8:45 AM on 5/27/25. V4 confirmed that R1, R2, R3 and R4 all reside on the same hallway. V4 was not able to provide any names of</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 6 other residents or staff members she interviewed after she spoke with R1, R2 and R3 regarding the 5/26/25 incident. V4 confirmed that R3 said she upset when V4 spoke with her, V4 stated "but she is always upset about something."</p> <p>R3's Nurse's Note dated 05/27/2025 at 1:13 PM entered by V4 (Social Service Director) documents "(R3) approached writer reporting a male resident was talking to her about sex in general. Stated he said to her "how can you live without sex?" Instructed (R3) to remove herself from these types of conversations if she feels uncomfortable. Reported to writer male resident did not touch her."</p> <p>V1 (Administrator) written statement, dated 5/26/25, documents "On 5/26/25 at approximately 11:30 PM I received a phone call from (V14 Certified Nurse Aide) stating that residents (R1 and R3) reported that (R2) had made sexual comments to them. I told (V14) to leave statements from them under my door." V1 confirmed that she did not speak to any other staff member other than V14 on 5/26/25 at around 11:30 PM. V1 confirmed that she did not instruct any staff members to increase monitoring or to begin an investigation with other staff members or residents.</p> <p>V6 (Licensed Practical Nurse) written statement documents "On 5/27/25 at approximately 1:00 AM (V17/Certified Nurse Aide) reported (R2) was in (R1 and R3)'s room touching their arms, rubbing their shoulders and making statements such as "are you bored, just sitting around here let's go to my room, do you want to have sex, let's go have sex. The women (R1 and R3) told staff about this incident during ice pass tonight, but when the female residents told (V5/Activities Aide) about the incident earlier in the day, (V5) informed the women to tell management or the nurse. The CNA reported it immediately to the nurse (V18/Registered Nurse) before I (V6) arrived and was told 'that's not my problem'. The female residents (R1 and R3) seemed very upset and tearful about this incident."</p> <p>R1's Nurse's Note, dated 5/27/25 at 2:20 AM, documents "CNAs reported that during ice pass, 2 female residents stated that this resident was making statements such as "are you bored just sitting here, let's go to my room, do you want to have sex, let's go have sex" while touching/rubbing both female resident's arms and shoulders. Residents felt like second shift didn't</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 7 care-they were very tearful and upset about this incident."</p> <p>R3's Nurse's Note, dated 5/27/25 at 2:23 AM and signed by V6 (Licensed Practical Nurse) documents "CNAs reported that during ice pass, resident stated a male resident came into her bedroom making statements such as 'are you bored just sitting here, let's go to my room, do you want to have sex, let's go have sex' while touching/rubbing arms and shoulders. This resident appears to be tearful and upset at this time."</p> <p>A written statement signed by V17 (Certified Nurse Aide), V14 (Certified Nurse Aide), and V15 (Certified Nurse Aide) documents "during ice pass and first round (on third shift) on 5/26/25 (R1) and (R3) told us that (R2) has been making unwanted sexual advances towards them they stated he told "aren't you bored around here? Let's go to my room and have sex." The ladies (R1 and R3) stated they reported it to (V5/Activities Aide) and she told them she would have to tell nursing staff and management about the situation. Both female residents (R1 and R3) were very upset about the issue as well. We (V17, V14, and V15) tried to tell the nurse (V18/Registered Nurse) around 11:00 PM and she said she was leaving, and it wasn't her problem."</p> <p>On 5/29/25 at 12:00 PM, V15 (Certified Nurse Aide) confirmed that she herself and V14 and V17 all reviewed and signed the written statement from 5/26/25. V15 confirmed that V14 (Certified Nurse Aid) reported the allegation to V18 (Registered Nurse) and V18 stated it was not her problem and that she was leaving. V15 reported that V18 then gathered her belongings and left the facility. V15 stated that she was not aware of any ongoing issues with any of the mentioned residents (R1, R2, R3 and R4). V15 stated that V14 (Certified Nurse Aide) then began calling "all management staff" regarding the incident and that V1 (Administrator) "finally called back and said to just leave written statements under her door." V15 stated that she has never been questioned about her written statement or any further concerns from any member of staff at the facility as of 5/29/25 at 12:00 PM. "You are the first to ask me any questions about this."</p> <p>On 5/29/25 at 2:15 PM V14 (Certified Nurse Aide) confirmed that she herself and V15 and V17 all reviewed and signed the written statement from 5/26/25. V14 stated that R1 and R3 reported to all three CNAs (V14,</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364		
(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) COMPLETION DATE
S9999	<p>Continued from page 8</p> <p>V15 and V17) that R2 was in their room rubbing their shoulders and saying inappropriate sexual stuff to them and was making them very uncomfortable. "I told (V15 and V17) we need to stop what we are doing and report this. We all three went to (V18/Registered Nurse) and she said she was not reporting anything because she was off at 11:00 PM and it was almost 10:45 PM. That upset all of us, so I started calling the on-call nurse who was V3 (Assistant Director of Nursing) approximately 6 times with no answer or return call, I tried (V2/Director of Nursing) twice with no answer and V1 (Administrator) answered on the second call. But even after I told V1/Administrator) that V18 refused to call her and that R1 and R3 were scared V1 only said "well leave a written statement under my door." "There is no way for me to know if any of this actually happened but what happened to protecting the residents? I specifically told (V1/Administrator) that (R1 and R3) were scared of (R2). No one came in, no one spoke to (R1 and R3) and reassured them they were safe or anything. I still have not been questioned by anyone at the facility about my written statement. You are the first person to ask any questions about this."</p> <p>On 5/30/25 at 10:00 AM V17 (Certified Nurse Aide) confirmed that she herself and V14 and V15 reviewed and signed the written statement from 5/26/25. V17 stated R1 and R3 reported to all three CNAs that R2 was rubbing their shoulders and saying "aren't you bored? Don't you want to go have sex with me?" V17 stated that all three CNAs reported R1 and R3's concerns to V18 (Registered Nurse) who stated it was not her problem because she was almost off work. V17 stated that V14 (Certified Nurse Aide) then started calling management staff to report both the fact that the nurse would not report the incident and that R1 and R3 were scared of R2.</p> <p>R2's Medical Record documents that he admitted to the facility on 07/01/2024 with diagnoses to include but not limited to "unspecified intracranial injury with loss of consciousness of unspecified duration, cerebral aneurysm non-ruptured, depression, mood disorder due to known physiological condition, insomnia and anxiety."</p> <p>R2's MDS (Minimum Data Set), dated 5/7/25, documents R2's BIMS (Brief Interview for Mental Status) was 15 of 15, indicating R2 is cognitively intact. R2's MDS documents R2 had no hallucinations or delusions. R2 had no physical or verbal behavioral symptoms directed at others or other behavioral symptoms not directed</p>	S9999		

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050880		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER PARKER NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 WEST FRECH STREET , STREATOR, Illinois, 61364			
(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) COMPLETION DATE
S9999	<p>Continued from page 9 towards others.</p> <p>R2's current Care Plan, dated 7/26/2024, documents "(R2) exhibits sexually inappropriate behavioral symptoms related to lack of self-respect, poor self-worth, feelings of inadequacy, Behavioral symptoms are manifested by making crude, sexually oriented, profane or suggestive remarks. Conduct an evaluation of the sexually oriented behavioral symptoms to determine what (R2) is communicating through the behavior, provide supportive interventions needed when inappropriate behavior is observed/reported."</p> <p>(B)</p>	S9999			