FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: C B. WING IL6007371 09/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6141 NORTH PULASKI ROAD PETERSON PARK HEALTH CARE CTR CHICAGO, IL 60646 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 000 Initial Comments S 000 Complaint Survey: 2387495/IL164182 \$9999 Final Observations S9999 Statement of Licensure Violations 300.610a) 300.1210d)6 300.2210b)2 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** 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: Attachment A Statement of Licensure Violations 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

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

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED B. WING IL6007371 09/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6141 NORTH PULASKI ROAD PETERSON PARK HEALTH CARE CTR CHICAGO, IL 60646 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 that each resident receives adequate supervision and assistance to prevent accidents. Section 300,2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to remove a faulty power cord resulting in a series of orange-red sparks accompanied by puffs of smoke and a series popping noises. This deficient practice has the potential to affect one of two residents (R3) reviewed for faulty power cords and could affect all residents in the entire building, as well as an indeterminable number of staff and visitors. Findings include: R3's Face Sheet documents R3 is a 66-year-old admitted to the facility on 5.11,2022 with diagnoses including but not limited to: Chronic Atrial Fibrillation, Type 2 Diabetes Mellitus, Dysphagia, and Pressure Ulcer of Sacral Region, Stage 4. R3's MDS (Minimum Data Set of 8.9.23) Section C (Cognitive Patterns) documents R3 is mildly cognitively impaired. Section G (Functional

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Status) documents R3 requires extensive assistance of two plus persons physical assist for

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AM. I reported it to her (R3's) nurse."

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED					
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 8	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			(X5) COMPLETE DATE				
S9999	Continued From page 3		S9999							
	On 9.14.2023 at 2:2 Practical Nurse) sai Nursing Schedule for 7:00 AM to 7:00 PM Team One and was R3's care on that da about the cord (fray It could be a problet could be a fire, it's h 9.14.2023 at 4:05 P said, "I already chai should have done, i mattress power conthe facility). So now that we rent when it checklist now."  On 9.15.2023 at 9:2 Director) said, I did with exposed wires) someone here knew reported it to me. Vi us about the expose because it's a hazal die. V3 said, I do ro residents if everythil logbook. Every day rooms. Do I visually visually inspect ever depend on the Nurs if there is a problem control, bed cord, it	29 PM, V7 (LPN-Licensed d, after reviewing Daily or 9.4.2023, she was working on that day; was assigned to the nurse responsible for ay. I don't remember anything ed cord with exposed wires). m, it's a short circuit, there nazardous.  M, V3 (Maintenance Director) nged the power cord. What we is inspect it (low air loss d) when it was delivered (to we will inspect any equipment is delivered. We have a delivered. We have a delivered to until you and I found it. If wabout it, they should have for (Family Member) never told ed wires. It should be fixed and, you don't want anyone to unds in the morning. I ask the ng is okay, then I check the I go into every resident's inspect every cord, no. I don't any day, I ask the resident. I es and CNAs to let me know to the I inspected every remote would take me six hours per nice Assistant) changed the								
	Member) said, "I sh	4 AM, V5 (R3's Family owed her (V7-LPN) the cord; n with me and (R3). I informed								

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STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
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IL6007371     8. WING     09/22/2023       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE												
PETERSON PARK HEALTH CARE CTR 6141 NORTH PULASKI ROAD												
CHICAGO, IL 60646												
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S9999	Continued From page 4		S9999									
	V4 (Social Service Designee) on Tuesday September 12, 2023, at 10:55 AM when she called me.											
	9.15.2023 at 12:35 PM, V4 (Social Service Designee) said, I was not informed about the exposed wires. R5 did not mentioned any exposed wires when I spoke with him. I would have mentioned the exposed wires to the Administrator and Maintenance.											
	of cord for R3's low	:51 AM, V5 emailed pictures air loss mattress pump. The was frayed with exposed										
	Member) said, "I fo when I was looking It always seems to thing I do when I co	:45 PM, V5 (R3's Family und the frayed power cord for the bed control (R3's) bed. be missing. So, that's the first time to visit her, I look for the he exposed wires when I was control."			정							
	7.28.2023) docume maintain equipment environment. All rest building environment maintenance depar aware of a malfunc of the building that issue to the maintenance depart	sident care equipment and the nt will be maintained by the trent. Any staff who is made tioning equipment or any part is in disrepair will report the nance department. The trent will address the issue e. Any equipment that cannot										
	and Sales Durable	(Vice President of Marketing Medical Equipment Company) LS900 True Low Air Loss										

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