Illinois Department of Public Health

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 03/21/2023

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: 2381626/IL156873, 2382106/IL157488 & 2382113/IL157491	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.610a) 300.1210b) 300.1210c) 300.3210t) 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 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	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These Requirements were not met as evidenced by: Based upon observation, interview and record review the facility failed to follow the abuse/neglect policy and failed to ensure that two of four residents (R3, R4) reviewed for abuse remained free from abuse. These failures have the potential to affect 45 (2 South) residents. On (2/21/23) R3 pushed R2 into R4 causing both residents (R2, R4) to fall, R4 sustained dizziness and head/neck/right shoulder pain rated 3 out of 10. Findings include: The (3/14/23) census includes 45 (2 South) residents. The (2 South) memory care unit is locked to prevent elopement. R3's diagnoses include dementia with agitation and other conduct disorders.	S9999		

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R3's (12/28/23) BIMS (Brief Interview Mental Status) affirms resident was unable to complete the interview. R3's cognitive skills for daily decision making: moderately impaired.

R3's care plan includes (12/23/22) presence of abuse factors: resident presents with behavioral symptoms. Wandering: resident going into and out of other resident's rooms. Resident demonstrates cognitive impairment related to dementia with agitation. (3/8/23) Behaviors: resident has been noted with taking items off nursing cart and throwing at wall/staff. Resident will at times make verbal threats to harm staff when attempting to redirect/de-escalate. Intervention: Psychiatric consult as indicated.

Progress notes affirm (R3) was sent to the hospital for aggressive behaviors on 2/21, 3/7, 3/9, 3/10, and 3/11 (2023). However R3's last psychiatric consult was documented 1/25/23.

R3's (2/21/23) progress notes state resident being aggressive towards another resident and pushed resident to the floor.

The (2/21/23) initial abuse report includes name of alleged victims (R2) and (R4). Alleged perpetrator (R3). Writer was informed (2/21/23) by Nurse that (R3) made contact with (R2) who lost her balance and bumped into (R4). (R4) was sent to hospital for evaluation due to fall.

The (3/14/23) census affirms R2, R3 and R4 reside on 2 South.

On 3/14/23 at 3:32pm, surveyor inquired about R3's behaviors. V13 (Certified Nursing Assistant) stated, "She (R3)doesn't want anyone to come in her (R3) room but she (R3) go into other rooms

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and take everything." R3 was subsequently observed by surveyor entering (3) other resident rooms and closing the doors however no redirection was provided. Surveyor inquired if R3 is aggressive. V13 responded, "She (R3) was fighting with another resident and throw them on the floor." Surveyor inquired which resident R3 was "fighting with". V13 replied, "(R2)". Surveyor inquired why R3 was entering R2's room (which was adjacent to R3's room) at this time. V13 stated, "That's a problem." [R2 was in the room when R3 entered].

On 3/14/23 at 3:55pm, R3 was observed entering R2's room again (uninvited). Surveyor stated, V13 just reported to surveyor that R3 was recently thrown on the floor by R2 and inquired why R2 and R3 reside next door to each other. V18 (Agency Nurse) responded, "It shouldn't be happening obviously there needs to be a separation." R3 subsequently exited R2's room entered room 209 and then room 210 (uninvited). V18 stated, "She's (R3) going back and forth, I'll try and keep her (R3) separated from the others." V18 verbally redirected R3 to go back to her room. Surveyor observed, R3 become verbally aggressive towards V18 entered her room then slammed the door shut. R3 immediately opened the door and entered the hallway. V18 stated, "She's got agitation, so I'll talk to the doctor about it."

On 3/20/23 at approximately 4:00pm, surveyor requested a recent psychiatric consult for R3 V2 (Director of Nursing) affirmed the last psychiatric consult was documented 1/23/23 (roughly 2 months ago).

R2's (2/2/23) BIMS affirms resident is rarely/never understood.

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On 3/14/23, at approximately 3:37pm, R2 was unable to communicate with surveyor due to cognitive status and communication barrier (Speaks Bosnian).

On 3/14/23 at approximately 4pm, surveyor relayed concerns regarding R3 currently residing next door to R2 (post 2/21/23 abuse) and R3 entering R2's room uninvited. V2 (Director of Nursing) affirmed, R2 would be moved to 2 South today [3 weeks after the incident].

R4's (3/7/23) BIMS determined a score of 15 (cognitively intact).

On 3/16/23 at 2:30pm, surveyor inquired about the (2/21/23) incident V19 (Staffing Coordinator) translated the conversation in Spanish. R4 stated she was walking and the next thing she knew her face, head and shoulder hit the floor. When she (R4) turned around there were 2 other people on the floor with her (R4). She (R4) doesn't know if she was pushed or what happened. R4 went to the hospital due to head and shoulder pain.

R4's (2/21/23) pain assessment affirms resident verbalized pain rated 3 out of 10 (pain location is excluded).

R4's (2/21/23) history & physical affirms patient states that she was bumped by another resident causing her to fall onto the floor. Patient states she did hit her head denies loss of consciousness but was complaining of dizziness at the time. Complaining of mild neck pain. Patient also complaining of right shoulder pain.

On 3/15/23 at 10:02am, V3 (Assistant Director of Nursing) affirmed R4 was also involved in the

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S9999	Continued From page 5 (2/21/23) incident. Surveyor inquired why R4 still resides on 2 South (where R3 resides). V3 stated, "We can move her to 2 North" [3 weeks after the incident]. On 3/15/23 at 11:45am, surveyor inquired about the regulatory requirements for abuse. V1 (Administrator/Abuse Coordinator) stated, "If there's a resident-to-resident abuse, we separate the residents." R3's (3/11/23) progress notes state resident going into other resident's room stealing items. Resident hurt writer's (V14/Agency Nurse) finger while swinging. Resident could not be redirected. Administered PRN (as needed) Ativan. Several hours later resident continues to curse and be abusive to staff and other residents. Resident hit resident when she went into resident's room to steal her blankets. On 3/20/23 at 1:46pm, surveyor inquired about R3's (3/11/23) incident. V20 (Agency Certified Nursing Assistant) stated, "I just know that R3 is very very aggressive. She flips out a lot, she wanders in other people's room and takes things like pillows and bedding and put it in her room. When we try to get it back, she'll (R3) fight. She'll (R3) swing at staff, scream, yell, curse you out. We (staff) were trying to calm her down, when we were trying to take the linen out her room, she (R3) ended up hitting the Nurse's finger or something like that. It can get a little tough at times because she's (R3) very strong." Surveyor inquired which resident was "hit" (per 3/11/23 progress note) V20 responded, "I don't know which resident it was." On 3/16/23 at 10:00am, V1 affirmed he was unaware of R3's (3/11/23) abuse and unsure	S9999		

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S9999	Continued From page 6 which residents were abused. On 3/16/23 at 10:54am, surveyor inquired about the requirements for staff that incur and/or witness abuse. V2 (DON/Director of Nursing) stated, "If they see abuse of course they need to report it. They need to separate the resident and assess both of them. The aggressive one needs to be monitored 1 to 1." On 3/21/23 at 10:24am, surveyor inquired about potential harm to residents if R3 pushed them (R2, R4) to the floor. V22 (Physician) stated, "If she (R3) is pushing somebody, they (R2, R4) could potentially be harmed. They (R2, R4) can sustain bruises and soft tissue injury, or contusion, they could break a bone its possible anything can happen." Surveyor inquired about potential harm to other residents if R3 had 5 recent episodes of aggressive behavior and is not monitored 1:1 and/or victims (R2, R4) reside with R3. V22 responded, "There's potential harm to the residents. I was not aware about that, nobody brought it to my attention." The abuse and neglect policy (reviewed 10/24/22) states in part: it is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse. If abuse is suspected the facility will: take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. (B) 2 of 3 300.3240b)c)e)g	S9999		

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Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These requirements were not met as evidenced by:

Based upon record review and interview the facility failed to ensure that staff report abuse to the Administrator and/or Designee, failed to report accurate information to IDPH (Illinois Department of Public Health) and failed to report resident to resident abuse to IDPH within regulatory requirements for three of four residents (R2, R3,

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S9999	Continued From page 8 R4) reviewed for abuse. These failures have the potential to affect 174 residents. Findings include: The (3/14/23) census includes 174 residents. R3's (2/21/23) progress notes state resident being aggressive towards another resident and pushed resident to the floor. The (2/21/23) initial abuse report includes name of alleged victims (R2, R4). Alleged perpetrator (R3). Writer was informed (2/21/23) by Nurse that (R3) made contact with (R2) who lost her balance and bumped into (R4). On 3/14/23 at 3:32pm, surveyor inquired if R3 is aggressive. V13 (Certified Nursing Assistant) responded, "She (R3) was fighting with another resident and throw them on the floor." Surveyor inquired which resident R3 was "fighting with" V13 replied, "(V2)". The (2/21/23) final abuse report was submitted to IDPH via email on 3/2/23 (9 days after the incident). Did the findings indicate that abuse occurred? No [V13 stated that R3 threw R2 on the floor]. On 3/15/23 at 11:45am, surveyor inquired about the regulatory requirements for abuse. V1 (Administrator/Abuse Coordinator) stated, "Within 2 hours it has to be reported to IDPH and within 5 business days for the final." R3's (3/11/23) progress notes state resident going into other resident's room stealing items. Resident hurt writer's (V14/Agency Nurse) finger while swinging. Resident could not be redirected.	S9999		

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Administered PRN (as needed) Ativan. Several hours later resident continues to curse and be abusive to staff and other residents. Resident hit resident when she went into resident's room to steal her blankets.

On 3/16/23 at 10:00am, surveyor inquired if V1 was made aware of R3's (3/11/23) abuse. V1 responded, "I don't think so I'm not sure." V1 reviewed the abuse incident binder and stated, "No, it's not here. I was not aware of that."

On 3/16/23 at 10:54am, surveyor inquired about the requirements for staff that incur and/or witness abuse. V2 (Director of Nursing) stated, "If they see abuse of course they need to report it. They need to call the abuse coordinator or the on-call nursing supervisor and report it immediately."

On 3/16/23 at 11:09am, surveyor inquired if V3 (Assistant Director of Nursing) was the (3/11/23) on call nurse. V3 stated, "Yes." Surveyor inquired if V14 reported R3's (3/11/23) abuse. V3 responded, "No, she never called me. The only one who called me was the Nurse Supervisor (V15). She (V15) just told me that the Nurse on the floor called 911 for (R3's) behavior. That's all that she (V15) said." Surveyor inquired about R3's (3/11/23) behavior V3 replied, "According to the supervisor (V15) she's (R3) going room to room and was aggressive, not aggressive. She was aggressive with a staff she did not say residents." Surveyor inquired if R3's progress notes were reviewed to determine what happened. V3 stated, "I did not able to review that one, I was sick since that one."

On 3/16/23 at 12:00pm, V1 presented R3's (3/11/23) initial abuse report submitted to IDPH

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on 3/16/23 (5 days after incident) which excludes witnesses [V14 documented R3's abuse therefore likely a witness].

On 3/20/23 at 2:15pm, surveyor inquired if R3's (3/11/23) abuse was reported. V14 (Agency Nurse) responded, "I told the supervisor that the resident was out of control, and I was having a hard time taking care of her. She was cursing and stealing things from resident rooms. She was aggressive and trying to hit the staff. She was swinging at me, and we sent her out." Surveyor inquired which resident R3 "hit" V14 replied, "I need to make an addendum to that note because I misworded that" and alleged that R3 was not abusive towards any residents [V14's documentation is clearly incongruent with this statement].

On 3/20/23 at 1:46pm, surveyor inquired about R3's (3/11/23) incident. V20 (Agency Certified Nursing Assistant) stated, "I just know that R3 is very very aggressive. She flips out a lot, she wanders in other people's room and takes things like pillows and bedding and put it in her room. When we try to get it back, she'll (R3) fight. She'll (R3) swing at staff, scream, yell, curse you out. We (staff) were trying to calm her down, when we were trying to take the linen out her room, she (R3) ended up hitting the Nurse's finger or something like that. It can get a little tough at times because she's very strong." Surveyor inquired which resident was "hit" (per progress note). V20 responded, "I don't know which resident it was, but I heard about it" and affirmed she (V20) overheard staff talking about the incident.

The (3/11/23) final abuse report submitted to IDPH (3/20/23) states did the findings indicate

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S9999	Continued From page 11 that abuse occurred? No. On 3/20/23 at approximately 1:30pm, surveyor inquired how V1 concluded that abuse did not occur if V14 reported that R3 "hit staff" and V20 observed R3 "strike her Nurse" (per summary of investigation). V1 advised that the facility only has to report resident abuse. Surveyor advised that R3 was a perpetrator of abuse on 3/11/23 and inquired if R3 hitting and/or striking staff is considered abuse. V1 responded, "Yes." The abuse and neglect policy (reviewed 10/24/22) states all allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to IDPH immediately not exceeding 2 hours after the initial allegation is received. A final investigation report will be submitted to IDPH within 5 working days. (C) 3 of 3 300. 1810 (I) All Cook County facilities with Colbert Class Members shall submit to the Colbert Lead Defendant Agency, or successor Colbert Lead Defendant Agency, on a monthly basis, an accurate census of all Medicaid-eligible residents, the previous month ' s voluntary and involuntary discharges conducted under Section 300.3300, including any voluntary and involuntary discharges scheduled to be conducted within 48 hours after the end of the reporting month. This monthly census must be submitted on the form prescribed by the Colbert Lead Defendant Agency using secure (encrypted) email, no later than the	S9999		

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S9999	Continued From page 12 fifth business day of each month. These requirements were NOT MET as evidenced by: Based on interview, and record review, the facility failed to submit to the Colbert Lead Defendant Agency, or successor Colbert Lead Defendant Agency, an accurate census of all Medicaid-eligible residents, no later than the fifth business day of each month. This failure has the potential to affect 140 Medicaid - eligible residents residing at the facility. Findings include: On 3/15/23 at 10:21 am, Surveyor asked V1 (Administrator) regarding census of all Medicaid-eligible residents.V1 (Administrator) said, "I (V1) submitted one on yesterday (referring to census report dated 3/15/23). When I (V1) pull the report up online, it does not show the date submitted (3/14/23), it only shows the date that the report was generated. The report I (V1) sent on yesterday (3/14/23) reflects February's census". On 3/15/23 at 10:24 am, V1 replied, "The November census was reported on January 1, 2023. I (V1) would have to check for December and January's census report. The report I (V1) sent on yesterday (3/14/23), is the report for February. On 3/15/23 at 10:30 am, and V1 said, " I (V1) would have to check. I'm (V1) still getting used to the spreadsheet, essentially it (referring to the census report) is supposed to be done by Social Service team on the 5th of the month. The previous Social Service Director has been sick and had to take a leave of absence. I (V1) been	S9999		

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 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 doing it (referring to the census report). On 3/15/23 at 10:42 am, Surveyor asked V1 regarding census reports for December 2022, January 2023, February 2023 and March 2023. V1 said, "Those (referring to January and December census report) were not sent. Those are just my personal reports that I (V1) have not sent to the Department yet ". On 3/15/23 at 10:45 am, Surveyor asked V1 why the reports only had the month on it (excluding an exact date of submission). V1 said, " It's a spreadsheet I (V1) don't have a means of tracking when I (V1) send in the report. I (V1) thought it was supposed to be done quarterly. I (V1) got a notification from the regulatory department for Colbert via email about it and that ' s what reminded me to submit the census report. It was late. I (V1) am not sure if a report was sent January 1, 2023". On 3/15/23 At 11:08 am V1 said, going forward I (V1) will definitely track the monthly reports. I (V1) will make sure that it is done by the 5th every month (referring to the census report). I'm getting another report mixed up with the census report ...that ' s why I (V1) thought it was to be reported quarterly ... It should be our Social Service Department that sends it (referring to the census), but really it's supposed to be me (V1). I (V1) know that I (V1) should oversee everything and make sure that it is being done. As of yesterday (3/14/23), V7 (Social Service Director) will be responsible for sending in the monthly census report. On 3/15/23 at 2:30 pm, V7 (Social Service Director) said, " I (V7) do not submit anything to the Department. I (V7) believe I (V7) read	S9999		

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S9999	Continued From page 14 somewhere that the census report is to be emailed by the fifth day of every month to a certain email. It is the Administrator who has been submitting them I (V7) believe. However, Social Services will now start to submit the reports ". On 3/16/23 at 3:28 pm, Surveyor inquired about the purpose of the census report. V1 said, "We are to send the report to ensure that all Medicaid-eligible residents are receiving all services". . On 3/16/23 at 3:30 pm, V1 said, "We don't have a policy strictly for Colbert. Our general discharge policy has some information about discharge planning for Colbert members". The 3/15/23 Census report included 149 Medicaid-eligible residents including 9 that were listed on the Previous Month's Voluntary Discharges Report. The facility reported a total of 140 Medicaid- eligible residents currently in the facility. Facility document titled Census Report dated 3/15/23 was reviewed, in conjunction with an email dated 3/14/23. V1 provided email was sent by V1 to the Colbert Decree regulatory body with the following attachment: Copy of Monthly Census Discharges Report (February). Review of documents titled: Census Report, Date of Report: December; and Census Report, Date of Report: January. Both reports excluded dates of submission to the Department. Surveyor requested monthly census submission for December 2022 through March 2023, but facility provided March 2023 monthly census	S9999		

Illinois Department of Public Health

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S9999	Continued From page 15 report for Medicaid- eligible residents. Review of March 2023 census report was sent on 3/14/2023, not by the fifth day of the month as required. Facility policy titled, Discharge Planning and Instructions revised 1/6/23 excludes information related to monthly census reporting for Medicaid-eligible residents. Facility email received by V1 (From Office of Health Care Regulation) dated December 30, 2022 reads, Skilled Nursing and Intermediate Facilities Codes were amended to require facilities to: Submit an accurate monthly census of all Medicaid-eligible residents. (C)	S9999		