

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007272	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/01/2017
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NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 3520 NORTH ROCHELLE PEORIA, IL 61604
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(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	S 000		
S9999	<p>Incident Report Investigation to incident of 1-26-17/IL92097</p> <p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.1210b) 300.3240a)</p> <p>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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review the facility</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/16/17

Illinois Department of Public Health

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S9999	Continued From page 1 failed to prevent abuse for one of three (R1) residents reviewed for abuse in the sample of three. This failure resulted in R1 crying and feeling that he may be "put out" with nowhere to go." Findings include: The facility Abuse Investigation documents, in part, "The video recording of (R1) and the entrance to the room was replayed from 11:44PM on 1/25/2017 to 7:39AM on 1/26/2017. (E8) Certified Nurse Aide (CNA) can be seen standing in front of (R1) as he is sitting in his wheelchair in his doorway. (E8) is speaking to (R1) and reached down, grabs his wheelchair and forcibly pulls him out of the doorway, letting go and allowing (R1) to run into the opposing wall and laundry barrel. (E8) enters the room immediately without looking where (R1) is going with total disregard for his safety." On 3/1/2017 at 12:00PM, E7 CNA stated, "On 1/29/2017, (R1) was tearful when he said that a CNA took (feces) and smeared it in his hair, stomach and in his mouth. (R1) did not know the name of the person but said he would know her if he saw her. E7 stated she reported it to the nurse, (E9) Licensed Practical Nurse (LPN). E7 stated she actually took report on 1/26/2017 from (E8). E7 said it was clear that (E8) was upset and frustrated that morning but E7 didn't think much about it. E7 stated R1 was clean and neat without an unclean body odor that morning. E7 explained she does not think E8 actually threw feces at R1 or smeared it in his hair because E8 would have probably had to have given R1 a shower. The facility investigation documents a statement	S9999		

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S9999	<p>Continued From page 2</p> <p>dated 1/30/2017 from (E9) LPN, "This nurse spoke with (R1) and asked what happened. Resident became tearful and stated, 'the CNA was mad at him because he had pooped on himself and said she should throw it in his mouth'. (R1) stated this occurred (R1) stated 'Thursday or Friday'...(R1) stated he did not tell anyone else because he was scared no one would believe him and he would be put out and have nowhere to go. Resident again became tearful."</p> <p>The 2/3/2017 facility Final Abuse Investigation Report for R1 documents the following conclusions have been determined, "Account of incident led investigators to believe (E8) was highly frustrated and had lost patience with (R1). Therefore its believed that (E8) did infact verbally and mentally abuse (R1)." for the incident with R1 dated 2/3/2017, documents E8 was "immediately terminated for verbal/mental abuse."</p> <p>(B)</p>	S9999		
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