STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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
F 520	Continued From page 59 On 8-14-13 at 1:05 PM. E23 (Restorative Nurse) stated that E23 attends all Quality Assurance (QA) meetings. E23 stated that "occasionally" a physician attends the QA meetings but was unable to state when a physician had last attended. Facility Quality Assurance (QA) attendance logs dated 1-10-13 to 8-09-13 do not include documentation that a physician attended any meetings. On 8-15-13 at 2:15 PM. E1 (Administrator) confirmed that there had been no physician in attendance at any of the facility's Quality Assurance meetings. A facility Census and Condition Report dated 8-12-13 and signed by E1 (Administrator) documents that at the time of the survey 82 residents resided in the facility.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

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SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 60	F9999		

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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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 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. (Section 3-202.2a of the Act)

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. Restorative measures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

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F9999	Continued From page 61 shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. 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 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders,	F9999		

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F9999	Continued From page 62 and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence by: Based on interview and record review the facility failed to investigate and report all allegations of suspected abuse and injury of unknown origin immediately to the administrator and state agency as required by facility policy for three of four residents (R13, R17, R21) reviewed for abuse in the sample of 17 and eight residents in the supplemental sample (R28, R31, R33, R34, R37, R38, R39 R40). Based on observation, interview, and record review the facility also failed to identify the physically aggressive behaviors of four residents, R18, R23, R32 and R38 toward other residents as abuse, and failed to put interventions in place to protect the other facility residents from being repeatedly subjected to abusive behaviors by R18, R23, R32 and R38 this resulted in further failure by the facility to do the following: A. Failure to protect three of three (R13, R17 and R21) residents who were victims of aggression on the sample of 17 and three residents who were	F9999		

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F9999	Continued From page 63	F9999		

victims of aggression (R28, R39 and R40) on the supplemental sample;
B. Failure to investigate incidents of aggression or injury of unknown origin for three of three residents (R13, R17 and R21) who were victims of aggression on the sample of 17 and seven residents (R28, R31, R33 ,R34, R37, R39 and R40) on the supplemental sample; and
C. Failure to report abuse or injuries of unknown origin to the facility administrator and state agency immediately for three of three residents (R13, R17 and R21) who were victims of aggression on the sample of 17 and seven residents (R28, R31, R33 ,R34, R37, R39 and R40) on the supplemental sample.

All of these failures have the potential to effect all 82 residents in the facility.

Findings include:
1. A physician's order sheet (POS) dated, 8/2013, documents that R18 has diagnoses which include: Asperger's Syndrome, Obsessive Compulsive Disorder, Schizophrenia, Depression, Cluster C Traits. The POS documents that R18 has medications which include: Ativan 1 mg (Milligram) intramuscularly injection to be given every six hours as needed for 72 hours dated 8-08-13, Risperidone 2 mg three times daily, Lamictal 100 mg two times daily, Klonopin 1 mg three times daily. The POS also included an order for Ativan 1 mg intramuscularly injection given as a now dose on dated 8-02-13.
A Minimum Data Set (MDS) Assessment, dated 6-20-13, documents that R18 is moderately cognitively impaired, independently mobile, and displayed verbal behavioral symptoms directed toward others four to six days per week. The MDS documents that R18's behaviors, "Put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 64	F9999		

others at significant risk for physical injury...Significantly disrupt care or living environment."
Nurse's Notes, dated 9/2012 through 12/2012, document that the first incident of R18, "trying to hit another resident," was 12-03-12. The remaining Nurse's Notes, dated 12/2012 to 8/2013, document multiple, frequent incidents of R18 hitting or attempting to hit facility staff and residents, entering resident rooms uninvited, throwing dishes, kicking, or attempting to hit others with R18's walker.
A facility incident report, dated 12-19-12, documents that R18 was, "hitting and kicking staff with closed hand and other residents." The incident report also indicates that R18 was witnessed kicking E27 (Registered Nurse). The incident report documents that R18 was removed, "from hostile environment to prevent harm from self and others."
A facility incident report, dated 3-18-13 documents that, "Another resident (R18) hit R39 on the back of the neck for no reason... R39 was sitting in reclining wheel chair in dining room." The incident report documents that, "Staff (counseled) on keeping R18 away from the other resident (R39) as much as possible and monitor closely when they are in the same room." A second incident report for the same incident, dated 3-19-13, documents that R18 also was attempting to, "kick another staff and resident." The incident report documented E 28 (Certified Nurse Aide), "Was in the dining area and resident hit at me twice and tried to kick me..."
A facility incident report, dated 8-12-13, documents that R18, "Entered another resident's room (R21) and struck R21 on the left forearm for an unknown reason. When asked why R18 did it, R18 said, 'I had to,' Neither resident was injured."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 65	F9999		

The incident report indicates that the "recommended steps to prevent recurrence" included, "R18 had recent med increase. R18 is to be redirected when going down hall and kept from going into others rooms without permission. When R18 is having behaviors redirect to R18's room or the nearest quiet place. Resident on 30 minute checks."

A facility incident report dated 8-13-13 documents that, "E14 (Assistant Director of Nurses) observed R18 running into another resident (R28) unintentionally with R18's walker pushing R28 up against the wall...(R18) also approached E14 in the medication room and struck E14 on the left wrist with R18's hand."

A care plan dated 9-13-12 documents that R18, "...has a history of verbal and physical aggression...R18 does not like to be touched...hits staff, throws trays." R18's behavior care plan interventions include: "explain R18 cannot use physical aggression and the importance of not being verbally or physically aggressive to anyone." The care plan also includes the intervention of providing, "1 to 1" supervision for R18 "Daily and as needed."

On 8-13-13 at 11:30 AM. R18 was in the hallway in front of the nurse's station. R18 was yelling unintelligibly while pushing R28 against the wall with a walker. E14 (Assistant Director of Nurses) approached R18 and loudly stated to R18, Don't do that." and led R18 down the hall towards R18's room.

On 8-14-13 at 9:05 AM. R21 stated that on 8-12-13 R18 entered R21's room and hit R21 in the arm. R21 stated that R18 has hit R21 at least four to five times in the past. R21 stated, "(R18) just rams me with the walker hard enough that if I was using my cane I would have gone down." R21 stated that, "(R18) is far too dangerous."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 66	F9999		

R21 stated that when R18 hit R21 on the arm facility staff removed R18 from R21's room while at the same time telling R18, "(R18) couldn't get any pudding or something." R21 stated, "I do everything to avoid (R18) but (R18) comes up behind me. (R18) lives right by me and (R18) will see me come out of my room then (R18) will come right out and come after me" R21 stated, "I'm 64 years old and I've never been bullied until now."

On 8-14-13 at 11:00 AM. E9 (Registered Nurse), E16, and E17 (Certified Nurse Aides) were at the nurses station. E9 stated that R18's behaviors had increased recently but that R18's behaviors were actually just getting back to normal now that R18's medical problems were improving. E17 stated that R18 had hit E2 (Director of Nurses)and E17 on 8-09-13 and had hit E17 also on 8-13-13. E17 stated, "(R18) got E2 last Friday and got me last Friday too. (R18) got me yesterday too." E17 stated, "Back about a month ago (R18) came up behind me and hit me on my back." E16 stated, "(R18)threw a walker at my back and on 8-09-13, (R18) came from behind and tried to hit me on my back." E16 stated, "And he tried to choke me." E16 stated that the incident had not been documented on an incident report because, "I knew that was just his behavior." E9 stated that some of R18's behaviors were because R18 wanted chocolate pudding stating, "I just walk R18 back to R18's room and give R18 what R18 wants."

On 8-14-13 at 2:55 PM. E14 (Assistant Director of Nurse's) stated that when R18 becomes agitated, threatens to hit or kick, or actually hits or kicks staff and residents, R18 is redirected to R18's room. E14 stated that R18, "gets better for awhile then gets aggressive. (R18) doesn't pick his people, it's just anyone who is near. (R18) will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 67 say, 'I need to hit you." R17's Nurse's Notes dated 8/12/13 at 5:50 p.m. document "it was brought to my attention a softball size lump had appeared on R17's left upper chest. It was not there during 2:30 p.m. rounds." The Nurse's Note at 7:15 p.m. documents "now bruised and appeared larger." R17's note at 7:15 p.m. documents "now bruised and appeared larger. send to emergency for evaluation, possible fractured rib." R17's Resident Transfer Form from the facility to the emergency room, dated 8/12/13 at 5:50 p.m., documents " injury of unknown origin, left upper chest, soft ball sized bump." R17's Preliminary Field Medical Report, dated 8/12/13, documents "hematoma above left nipple, bruise." R17's Emergency Transport Patient Care Report documents "large hematoma above left nipple, contusions and bruising all over body." The form documents chest, upper left arm and upper left leg as "soft tissue swelling and bruising." This form also documents under the Narrative section "(R17) was found laying in bed in the facility. "large edematous lump above left nipple up to shoulder about the size of a baseball. Patient (R17) also has bruising to his left upper arm and all across his chest. There is also bruising noted on legs. RN (Registered Nurse) stated being unsure of what happened to the patient but whatever occurred must have happened between 2 PM and 5 p.m. that day (8/12/13)." R17's Summary of Current Hospitalization Emergency Room Note, dated 8/12/13, documents R17 was admitted from the facility with left chest hematoma. It also documents,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 68	F9999		

"The emergency room staff contacted elder abuse hotline due to multiple ecchymotic(bruising) areas to skin and concern for abuse." Under the section of this form titled Assessment it documents "left chest hematoma, uncertain etiology, multiple bruises on body, social services following regarding potential elder abuse." R17's hospital record documents "5 inch diameter hematoma on left anterior chest. Ecchymosis (bruising) in left axillary region. Ecchymosis on right anterior chest wall. Multiple small lesions over legs." On 8/13/13 at 9:22 AM, Z2 (Admitting Emergency Room Physician) confirmed that the above-referenced note accurately represents R17's condition on admission to the Emergency Room.

On 8/13/13 at 11:45 AM, R17 was unable to respond appropriately to questions and just repeated "yes." R17 had a softball size raised area on R17's left upper chest. R17 had dark purple bruising in the left axilla which extended down to the elbow. R17's entire left bicep area was bruised. R17 had scattered bruising all the way across the chest just below the nipple line. R17's left foot had purple bruising starting at the left great toe and extending up the length of the foot about 1 1/2-2 inches wide. R17 had a pea sized scabbed area on the left great toe and left knee.

On 8/13/13 at 12:45 p.m. E13 (Nurse) stated that on 8/12/13 at 2:30 p.m. R17 was fine but when E15/CNA (Certified Nursing Assistant) got R17 up for dinner is when a red flat areas were discovered on R17's left chest, "don't know what it was, no one heard any noise or commotion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

(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
F9999	Continued From page 69	F9999		

from R17 and R18's room." E13 stated E2 (Director of Nursing) instructed E13 to chart the red area as an injury of unknown origin. E13 stated after dinner E13 reexamined R17 and found the red area to be bruised. E13 stated being "at loss as to what happened to R17."

On 8/13/13 a signed statement by E15 CNA (Certified Nursing Assistant) documented on 8/12/13 at 5:30 p.m. E15 went to get R17 up for dinner and noticed a large bump on R17's left chest. E15 asked R17 what happened and R17 stated "(R18) been hitting me."

On 8/14/13 at 11:00 a.m. E16/CNA stated the following: Last Friday (8/9/13), between 9:45 a.m. and 10:00 a.m., E13 (Nurse) asked for help because R18 was in his room fighting with R17. E16 saw R18 hit R17. E13 (Nurse) directed E16 to get R17 up and out of his room because R18 was hitting R17 in his chest. E16 started getting R17 up and E13 had to hold R18 back so the staff could get R17 up. E13 also saw R18 hit R17.

On 8/14/13 at 11:00 a.m. E9/LPN (Licensed Practical Nurse) stated the following: Last Friday (8/9/13) E13 (Nurse) had staff get R17 up and out of is room because R18 was hitting R17 in the chest. E9 saw R18 hit R17. E13 (Nurse) asked for help because R18 was fighting with R17 and E13 had to hold R18 so staff could get R17 up.

2. R23's POS dated 3-1-13, documents R23 had diagnoses of Impulse Control, and Mood Disorder. R23 was discharged from the facility on 7-7-13.

R23's Nurse's Notes, dated 12-21-12 at 2:45 a.m., document R23 hit R40 in the mouth

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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F9999	Continued From page 70	F9999		

because R40 took R23's radio and ate R23's food. The accident report does not include interventions to prevent a recurrence of R23's behaviors.

R23's nurse's notes dated 1-8-13 at 8:00 a.m., document R23 was "yelling and telling people to get out of the room."

A facility report dated 3-26-13 at 9:43 a.m. and signed by E2 (Director of Nursing), documents on 3-25-13 at 5:45 p.m., R13, who has a diagnosis of Senile Dementia, walked into R23's room. R23 became upset because R13 entered the room and R23 pushed R13 down to the floor. R13 was sent to the emergency room for complaints of right hip pain. R13's pelvis and right hip x-ray dated 3-25-13, documents R13 had two acute fractures of the pelvis. The facility report documents R23 was ticketed for battery and given a notice to appear in court.

R23's Nurse's Notes, dated 3-25-13 at 5:45 p.m., document R23 "got mad" because another resident came into R23's room, and R23 pushed the resident (R13) down. The 3-25-13 Nurse's Notes document R23 felt no remorse and R23 stated, "No one should come into my room."

On 8-14-13 at 9:15 a.m., E6 (CNA) stated R23 would curse and fight with staff and residents almost everyday. E6 stated the residents were scared of R23.

On 8-14-13 at 10:30 a.m., E9 (Licensed Practical Nurse/LPN) stated R23 was physically and verbally abusive to residents and staff. R23 stated if other residents entered R23's room, R23 would push the residents out of the room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 71 throw things at them. On 8-15-13 at 1:15 p.m., E26 (Social Rehabilitation Worker) stated R23's interventions to deal with behaviors were talking with R23 and telling R23 "you can't hurt people." E26 stated "I was unaware of (R23) ever hitting other residents." E26 stated no new interventions were implemented on R23's care plan when R23 was verbally and physically aggressive towards R40 on 12-21-12 or towards R13 on 3-25-13. On 8-13-13 at 2:40 p.m., E1/Administrator stated R23 was known to not like other residents in R23's room or space. On 8-13-13 at 11:10 AM, E1 stated that none of the incidents listed above in examples 1 and 2 were reported or investigated as abuse because the incidents were due to "behaviors" 3. A facility incident report dated 5/1/13 documents R32 punched R 34 in the head 3 times and then R32 pushed R34's wheelchair causing the wheelchair to propel. R32's history and physical documents R32 has a history of verbal and physical aggression and of making false accusations. R32 ' s care plan includes no documentation of review or new intervention after the 5-1-13 incident. An abuse investigation was not initiated. The incident form was not signed by E1 and IDPH was not notified until 5/2/13, 1 day later. On 8/13/13 at 11:10 a.m. E1 confirmed that the incident was not reported or investigated as abuse and stated "well, they are boyfriend and girlfriend."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 72	F9999		

4. A facility incident report dated 6/9/13 at 7:30 PM documents R33 was found on the floor unresponsive with a laceration to the left eye. R33 was sent to the hospital and found to have a Intercranial Hemorrhage. E1 did not sign the form until 6/10/13. IDPH was not notified until 6/10/13 at 9:43 a.m. O8-13-13 at 11:10 AM, E1 stated that this injury of unknown origin was not investigated as possible abuse.

O8-13-13 at 11:10 AM, E1 stated that this injury of unknown origin was not investigated as possible abuse.

5. A facility incident report dated 6/18/13 at 1:00 p.m. documents R38 grabbed R37's walker, R37 then struck R38 in the eye. R38 then threw water on R37. E1 ' s signature on the incident report form is dated 6/19/13. IDPH was notified of the incident via fax on 6/19/13 at 10:10 a.m.

The care plan for R38 includes no documentation of review or new intervention after the 6-18-13 incident.

On 8/13/13 at 11:10 a.m. E1 confirmed that the incident was not reported or investigated as abuse.

6. R31's incident report dated 3/1/13 at 3:45 p.m. documents R31 was noted to have swelling and bruising to the 4th finger on the left hand which was later found to be fractured. The incident report under the section titled "describe exactly what you observed or heard" documented "unable to make statement clear, stated she sleeps and had nightmares and that is how it happened, no witnesses." R31's Physician order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	08/22/2013

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F9999	Continued From page 73 sheet dated 8/1/13 documents R31 has Disorganized type Schizophrenia and Dementia. R31's history and physical documents R31 has delusions, hallucinations, poor judgement, poor memory, verbal aggression and flight of ideas. An abuse investigation was not completed. E1 (Administrator) signed the incident form on 3/4/13. The incident form was faxed to IDPH 3/4/13, 3 days after the injury of unknown origin occurred. On 8/13/13 at 11:10 a.m. E1 (Administrator) stated E1 did not investigate this bruising and swelling as abuse because "you just have to know her (R31)." (A)	F9999		