STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E888	A. BUILDING _____ B. WING _____	C 03/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE WILLOWS	3520 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 000	INITIAL COMMENTS	F 000		
F 323 SS=D	Complaint 1320713/IL61739 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop interventions to prevent recurring falls for one of three residents (R3) reviewed for falls in a sample of 5. Findings include: Face sheet for R3 lists an admit date of 11/11/11 and includes the following diagnoses: Dementia due to Brain Injury, Depression, Borderline Intellectual Functioning, Obesity and Seizure Disorder. Incident Report Investigation dated 9/7/12 at 9:30 AM for R3 documents, "Noted with hematoma and bruising to facial area. Resident stated he fell down when he went to his room." On 3/5/13 at 2:45 PM, E12/ Care Plan Coordinator stated the intervention for R3 regarding the fall on 9/7/12 was to "counsel R3 to use his call light."	F 323		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Incident Report Investigation dated 11/4/12 at 10:50 PM for R3 documents, Resident noted per staff throwing self to floor and landed on his right side. No visible seizure activity noted. No apparent injuries noted... On 3/5/13 at 2:45 PM, E12 stated the intervention for R3 regarding the incident on 11/4/12 was to provide 1:1 to determine why R3 threw himself on the floor. Incident Report Investigation dated 12/28/12 at 11:45 PM for R3 documents, Resident in his room when noted laying on the floor beside his wheelchair. Stated he was transferring self from chair to his wheelchair when he fell to floor. On 3/5/12 at 2:45 PM, E12 stated the intervention for R3 regarding the fall on 12/28/12 was to encourage resident to ask for assistance. Incident Report Investigation dated 1/3/13 at 8:45 PM for R3 documents, "Nurse was alerted by female peer that (R3) had fallen in her bathroom. R3 stated he was trying to transfer, his foot got caught and he fell. R3 denies hitting his head. Nurse assessed resident and noted complaint of right knee pain. Physician notified and verbal order for x-ray of right knee. X-ray results are negative." On 3/5/12 at 2:45 PM, E12 stated the intervention for R3 regarding the fall on 1/3/13 was to get an X-ray and she (E12) wasn't here then." There were no new interventions added to R3's care plan. Incident Report Investigation dated 1/5/13 at 8:30 AM for R3 documents, Resident (R3) in his room when noted on floor on his left side. Resident was transferring self from wheelchair to bed when he	F 323		

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F 323	Continued From page 2	F 323		

lost balance and fell. Able to move to sitting position. Refused assistance from staff. Refused to speak. Agreed to transfer at 11:20 AM. Complained of pain and grimacing upon transfer. Ambulance called and resident taken to hospital for evaluation and treat. Admitted with diagnosis of fracture to right femur.
History and Physical from local hospital dated 1/6/12 for R3 documents that R3 was admitted to the local hospital on 1/5/13 with a right distal femur fracture secondary to a ground level fall.
On 3/5/12 at 2:45 PM, E12 stated the intervention for R3 regarding the fall on 1/5/13 was to encourage R3 to wear his immobilizer and she E12 wasn't here then.

Incident Report Investigation dated 2/23/13 at 2:00 PM for R3 documents, Resident noted on bathroom floor. Resident states he was transferring self from toilet to wheelchair when he slipped and fell.
On 3/5/12 at 2:45 PM, E12 stated there were no interventions for R3 regarding the fall on 2/23/13, that was a Saturday.

Incident Report Investigation dated 2/24/13 at 11:45 AM for R3 documents, Resident preparing for X-ray of right knee when he slid out of his wheelchair. Nurse notified. Nurse and CNA (Certified Nursing Assistant) assisted resident back into wheelchair. Resident unable to straighten leg for X-ray and began to complain of right knee pain.
History and Physical from local hospital dated 2/24/13 lists an admission diagnosis of right femur fracture.
X-ray report dated 2/24/13 for R3 documents, "There is soft tissue swelling of the distal thigh

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F 323	Continued From page 3 and knee with a displaced, intra-articular fracture of the distal femur. The fracture displays evidence of early healing and has associated callus..." Clinical record for R3 indicates he was discharged from the facility to the hospital. On 3/5/13 at 12:45 PM, R3 was sitting in a wheelchair in his room at a sister facility. R3 had an immobilizer on his right leg. R3 stated he remember the day he fell and hurt his leg. R3 stated he had one of his epileptic seizures and fell and had to go to the hospital because he injured his leg. On 3/5/13 at 1:45 PM, E13/Medical Director stated he could not verify if R3 had a right femur fracture or a history of a seizure disorder without looking at the record.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to administer four medications within facility policy time frames for one resident (R6) and failed to administer one medication to a resident (R7) in a sample of 5 for a facility medication error rate of 12 percent out of 41 opportunities. Finding include:	F 332		

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F 332	Continued From page 4	F 332		

1. On 2/26/13 at 3:30 PM, E14/RN (Registered Nurse) administered Risperdal 2 mg (milligrams), Risperdal 3 mg, chlorpromazine 50 mg and chlorpromazine 100 mg to R6.

Physician's Orders dated 2/1/13 through 2/28/13 for R6 documents the following orders:
Risperdal 2 mg tablet 1 tab BID (twice daily) 10:00 AM and 2:00 PM
Risperdal 3 mg tablet 1 tab BID 10:00 AM and 2:00 PM
Chlorpromazine 50 mg 1 tab BID 10:00 AM and 2:00 PM
Chlorpromazine 100 mg 1 tab BID 10:00 AM and 2:00 PM

Facility Policy titled, "Medication Pass" with a review date of 5/27/08 documents, "Medications are to be passed no more than 60 minutes before to 60 minutes after the scheduled time."

2. On 2/26/13 at 3:40 PM, E14/RN failed to administer Chantix 1 mg to R7.

Physician's Orders dated 12/6/12 documents, "Chantix (follow instructions on package) for smoking cessation."

When E14/RN was asked why she did not administer the Chantix she stated, "Oh, I forgot."