DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14E888	B. WING			C 08/22/2013	
NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE WILLOWS				3	TREET ADDRESS, CITY, STATE, ZIP CODE 520 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 PREFI TAG	x	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=G			F	323			
	as is possible; and ea	as free of accident hazards					
	by: Based on interview a staff failed to impleme accordance with the r resident (R1) of three history of falls. This fa	is not met as evidenced and record review, facility ent safety precautions in resident care plan for one e residents reviewed for a ailure resulted in a forward ined a forehead laceration					
	Findings include:						
	AM indicated that R1 wheelchair onto the fl indicated that R1 sust to the forehead with n	fort dated 8/15/13 at 9:05 fell straight out of R1's oor at that time. The report tained a large open wound nuch bleeding. The report was sent to the hospital via tion.					
	pertaining to R1's fall members were instruction						

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.

Facility ID: IL6007272

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NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE WILLOWS CA	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 3520 NORTH ROCHELLE PEORIA, IL 61604 CAL DEPLICIENCY MUST BE PRECEDED BY PULL FREFIX CAL DEPLICIENCY MUST BE PRECEDED BY PULL FREFIX TAG TAG DEPLICIENCY MUST BE PRECEDED BY PULL FREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DEPLICIENCY MUST BE PRECEDED BY PULL TAG TAG TAG TAG			14E888	B. WING _				
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 1 Employee Report forms attached to the fall investigation indicated that Certified Nurse Aides (E5 to E8) and Licensed Practical Nurse (E4) were all disciplined and given a final warning for "poor nursing care" by the "failure to provide and apply bilateral foot pedals and safety self release belt to prevent injury and falls as careplanned." R1's hospital Emergency Department report dated 8/15/13 indicated that R1 had a "U shaped" 2.5 cm (centimeter) laceration on the frontal area of the head. R1's 2013 Fall Risk Assessment sheet indicated on 1/1/13, 3/27/13, and 6/25/13 that R1 had a risk score of "17," where a score of an eight or higher was defined as a high fall risk. According to R1's care plan updated on 6/21/13, R1 fell from the wheelchair on that date and lacerated R1's forehead. The care plan then implemented a self-release seatbelt safety intervention for R1's wheelchair. E1 (Administrator) stated on 8/21/13 at 3:25 PM that the five staff members (E4 to E8) were disciplined in regards to R1's 8/15/13 accident for not following R1's care plan and failing to have foot pedals on R1's wheelchair. E1 said that the facility has an unwritten policy that foot pedals are	NAME OF PROVIDER OR SUPPLIER				3520 NORTH ROCHELLE		00/22/2013	
Employee Report forms attached to the fall investigation indicated that Certified Nurse Aides (E5 to E8) and Licensed Practical Nurse (E4) were all disciplined and given a final warning for "poor nursing care" by the "failure to provide and apply bilateral foot pedals and safety self release belt to prevent injury and falls as careplanned." R1's hospital Emergency Department report dated 8/15/13 indicated that R1 had a "U shaped" 2.5 cm (centimeter) laceration on the frontal area of the head. R1's 2013 Fall Risk Assessment sheet indicated on 1/1/13, 3/27/13, and 6/25/13 that R1 had a risk score of "17," where a score of an eight or higher was defined as a high fall risk. According to R1's care plan updated on 6/21/13, R1 fell from the wheelchair on that date and lacerated R1's forehead. The care plan then implemented a self-release seatbelt safety intervention for R1's wheelchair. E1 (Administrator) stated on 8/21/13 at 3:25 PM that the five staff members (E4 to E8) were disciplined in regards to R1's 8/15/13 accident for not following R1's care plan and failing to have foot pedals on R1's wheelchair. E1 said that the five stail wheelchair. E1 said that the facility has an unwritten policy that foot pedals are	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
resident can self-propel themselves in the wheelchair with their feet.	F 323	Employee Report for investigation indicate (E5 to E8) and Licen were all disciplined a "poor nursing care" is apply bilateral foot p belt to prevent injury R1's hospital Emerg dated 8/15/13 indicas shaped" 2.5 cm (cenfrontal area of the her R1's 2013 Fall Risk on 1/1/13, 3/27/13, a score of "17," where was defined as a hig care plan updated of wheelchair on that d forehead. The care p self-release seatbelt wheelchair. E1 (Administrator) sithat the five staff med disciplined in regardinot following R1's cafoot pedals on R1's of facility has an unwritt to be on all resident resident can self-pro	rms attached to the fall ed that Certified Nurse Aides used Practical Nurse (E4) and given a final warning for by the "failure to provide and edals and safety self release and falls as careplanned." ency Department report ted that R1 had a "Unitimeter) laceration on the ead. Assessment sheet indicated and 6/25/13 that R1 had a risk a score of an eight or higher the fall risk. According to R1's in 6/21/13, R1 fell from the ate and lacerated R1's plan then implemented a safety intervention for R1's atted on 8/21/13 at 3:25 PM mbers (E4 to E8) were so to R1's 8/15/13 accident for are plan and failing to have wheelchair. E1 said that the ten policy that foot pedals are wheelchairs unless the pel themselves in the	F3	23			