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 08/22/2013

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=G	Investigation of Complaint # 1323457/IL65042. 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 interview and record review, facility staff failed to implement safety precautions in accordance with the resident care plan for one resident (R1) of three residents reviewed for a history of falls. This failure resulted in a forward fall in which R1 sustained a forehead laceration requiring sutures. Findings include: A facility Incident Report dated 8/15/13 at 9:05 AM indicated that R1 fell straight out of R1's wheelchair onto the floor at that time. The report indicated that R1 sustained a large open wound to the forehead with much bleeding. The report also indicated that R1 was sent to the hospital via ambulance for evaluation. An Incident Report Investigation dated 8/15/13 pertaining to R1's fall indicated that staff members were instructed and disciplined regarding use of the seatbelt for R1. Facility	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 1	F 323		

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 to be on all resident wheelchairs unless the resident can self-propel themselves in the wheelchair with their feet.