Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007298	A. BUILDING _____ B. WING _____	08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE PINES	3614 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) COMPLETE DATE
S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)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. The written policies and procedures shall be formulated by a 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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: 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: 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, 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.	S9999		

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to create and implement fall interventions for two of 10 residents (R5 and R17) reviewed for falls in the sample of 20. This failure resulted in R5 experiencing several falls and eventually being hospitalized for a Subdural Hematoma and R17 sustaining head injuries requiring sutures as as a result of multiple falls. Findings include: The facility Fall Policy and Procedure, dated 2/2017, documents "2. Individualized interventions will be developed for each resident to prevent falls and injuries, and included on the care plan. 4. The incident report will include a follow-up investigation to the fall which will include the date, time, type, and location of the fall, assigned staff and any injuries sustained from the fall. 5. Care Plans will be put into place for any individual who has had a fall. This will include (b.) An updated, realistic goal related to the fall prn (as needed). 6. Adjustments to ensure maximum safety for the resident will be made in the residents care plan when recurring falls continue despite current plan of care, identifying the resident's risk factors, and need for any changes in plan of care and fall prevention devices if necessary." The facility Fall Follow-Up Procedure, dated 2/2017, documents, "It is the policy of our facility to perform fall follow-up investigation to ensure adequate care plan measures are in place. Investigation to include at minimum: 8. Suggestions for prevention and/or recommendations in relation to care plan for	S9999		

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S9999	Continued From page 3	S9999		

prevention."

1. Admission Record for R5 dated 06/09/17 documents the following diagnoses: Chronic Obstructive Pulmonary Disease; Dysphagia; Dysarthria and Anarthria; Bipolar Disorder; Hemiplegia left side; and Reduced Mobility.
R5 most current MDS (Minimum Data Set) of 07/04/17 documents that R5 is ambulatory with assistance and needs assistance with transfers.

On 8/15/17 at 10:30 am to 4:00 pm and on 8/16/17 at 8:00 am to 3:00 pm, R5 was sitting in (R5's) wheel chair propelling self inside and outside the facility independently.

The Incident/Accident Report for R5, dated 11/15/16, documents R5 stood up from (R5's) wheel chair, at the Nurses Station and fell to the floor and received an abrasion to (R5's) right eye, bridge of nose, and to left knee.

The Care Plan for R5, dated November 2016 through August 2017, does not include fall intervention's for R5's 11/15/16 fall.

The Incident/Accident Report, dated 3/11/17 at 5:20 pm, document R5 stood up from (R5's) wheel chair at the Nurses Station and fell to the floor, sustained no injuries, and was "stationed close to nurse for observation."

The Incident/Accident Report, dated 3/11/17 at 5:50 pm, documents R5 stood up again from (R5's) wheel chair at the Nurses Station, fell to the floor, hitting (R5's) head, and (R5) became unresponsive with unresponsive pupils.

The hospital Discharge Summary, dated 3/28/17,

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S9999	Continued From page 4 documents R5 was "hospitalized" for a "Traumatic Subarachnoid Hemorrhage with loss of consciousness of 30 minutes or less." The History and Physical for R5, dated 3/31/17, documented and signed by E5 PCP (R5's Primary Care Physician)/Medical Director, documents R5 "Fell recently and went to (local hospital) March 11, found to have a cerebral bleed." On 8/18/17 at 9:00 am, when asked, E4 CPC (Care Plan Coordinator) confirmed there are no new fall prevention interventions for R5's 11/15/16 or 3/11/17 falls. E4, CPC stated (E4) will update a resident's fall care plan by inputing the fall date and medical treatments related to injuries but does not include new fall prevention interventions On 8/17/17 at 12:00 pm, E3 DON (Director of Nursing) stated "We don't do root cause analysis here," the nurses fill out the Incident/Accident Report forms, complete the Follow-Up reports, and forward the forms to (E3). E3 also stated, E4 CPC (Care Plan Coordinator) is responsible to put new fall interventions onto the care plans. On 8/17/17 at 11:00 am, E5 PCP (Primary Care Physician)/Medical Director, stated he would "100 percent" expect the facility to do a fall investigation, find the root cause of a fall, and to implement appropriate fall interventions for each resident. 2. Facility MDS for R17 dated 07/03/17 docments that R17 requires extensive assistance for transfer and ambulation. On 8/16/17 at 11:20 am R17 was laying in bed with eyes closed, swelling and dark purple	S9999		

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S9999	Continued From page 5 discoloration surrounding (R17's) entire left eye area, with four intact sutures to R17's left lateral eye area. On 8/16/17 at 12:00 pm to 3:10 pm and on 8/17/17 at 8:30 am to 12:00 pm, during cares, while sitting in the dining room, and while sitting in television room, R17 repeatedly stood up independently with an unsteady balance and attempted to ambulate with an unsteady gait. The following Incident/Accident Reports for R17, dated 3/13/17, 3/31/17, 4/28/17, 6/16/17, 7/15/17, 8/7/17, and 8/10/17, document R17 falling to the floor with the following injuries: 3/13/17 two lip wounds, 4/28/17 laceration and bruise to right eyebrow, 6/16/17 laceration to upper lip and jaw, 7/15/17 laceration to nose and head bruising, 8/7/17 laceration and Hematoma to right cheek, and 8/10/17 with "gash to left eye brow". The Incident/Accident Reports for R17, dated 8/7/17 and 8/10/17 document R17 going to the hospital emergency department and receiving sutures. On 8/18/17 at 9:00 am, when asked, E4 CPC (Care Plan Coordinator) confirmed there are no fall prevention interventions for R17's falls on 3/13/17, 3/31/17, 4/28/17, 6/16/17, 7/15/17, 8/7/17, and 8/10/17. (A)	S9999		