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 ____	08/12/2021

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 Licensure Survey Facility Reported Incident Investigation IL136656 of July 28, 2021	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610 a) 300.696 a) 300.696 c)7) 300.1020 a)b) 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 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and	S9999	**Attachment A** **Statement of Licensure Violations**	

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include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.

c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):

7) Guidelines for Infection Control in Health Care Personnel

Section 300.1020 Communicable Disease Policies

a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).

b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility.

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement the facility's

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S9999	Continued From page 2 COVID 19 policies and procedures and the Centers for Disease Control and Protection (CDC) guidance regarding Personal Protective Equipment (PPE) usage, hand hygiene and isolation precautions, and failed to identify and prepare designated areas with dedicated staff to care for and monitor residents with confirmed COVID-19, immediately notify staff of residents testing positive for COVID-19, and follow CDC guidance regarding a PUI (person under investigation) resident (R83). These failures resulted in facility staff going in-between COVID-19 positive resident rooms (R50 and R8) and an observational isolation resident room (R83) passing meal trays, medications and providing cares without changing PPE and performing hand hygiene, and then leaving R8, R50, and R83's rooms without disinfecting their eye protection to pass trays and assist residents in the main dining room. These failures have the potential to affect all 98 residents residing in the facility. Findings include: The CDC recommendations, dated 3/29/21, document, "Determine the location of the COVID-19 care unit and create a staffing plan. -Doing this before residents or HCP (Healthcare Personnel) with SARS-CoV-2 (COVID-19) infection are identified in the facility will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit. The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with SARS-CoV-2 infection.	S9999		

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S9999	Continued From page 3 Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum, this should include the primary nursing assistants (CNAs) and nurses assigned to care for these residents." The CDC recommendations dated 2/23/21, document, "Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection. Roommates of residents with SARS-CoV-2 infection should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents while they are in quarantine (i.e., for the 14 days following the date their roommate was moved to the COVID-19 care unit). Hand Hygiene -HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS (Alcohol Based Hand Sanitizer) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE."	S9999		

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The Facility's Coronavirus/COVID-19 policy (undated) documents, "The Infection Control Nurse (V2/Director of Nursing) will monitor bulletins from national health authorities, state and certified local health departments, as well as healthcare associations for guidance. The (Infection Control Nurse) may also call those authorities for updates and clarification of new or unclear guidance; Every attempt will be made to assign designated staff to work with the residents in isolation. Likewise, those in quarantine will have staff members dedicated to work with them; Should residents insist upon smoking, they will only be allowed to go to the smoking patio as long as each resident is able to maintain a distance of at least 6 feet apart."

The Facility's Personal Protective Equipment (PPE) Procedure: Donning and Removal policy (undated), documents, "Once patient-care tasks are complete, carefully remove PPE and discard it in the receptacles provided. Immediately perform hand hygiene."

R50's SARS-COV-2 Virus PCR (Polymerase Chain Reaction) Test Report dated 7/30/21, documents R50 was positive for COVID-19.

On 8/9/21 at 11:27 a.m., there was a plastic barrier on the C-Hall labeled, "Airborne Isolation Precautions" that had a large opening where the two pieces of plastic were supposed to meet. The opening was approximately the size of a basketball. There were two resident rooms on the COVID-19 unit, behind the plastic barrier.

On 8/9/21 at 11:30 a.m., V5 (Certified Nurse Aide/CNA) exited the COVID-19 unit. V5 stated there were two rooms and three residents on the COVID-19 unit. V5 stated R50 was the only

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S9999	Continued From page 5 COVID-19 positive resident in the facility and resided in one of the rooms and then R8 and R83 resided together in the room directly across the hall from R50. V5 stated R50 needed assistance to get out of the back door to smoke. V5 stated both R50's room and R8/R83's room doors were open. V5 stated both R8 and R83 needed hands on assistance with cares. V5 stated, "I'm not for sure why (R8 and R83) are in isolation but I can find out." V5 stated R83 is non-compliant with the isolation due to her mental status and was out in the dining room sitting with other residents at this time. V5 stated V5 had the entire C-Hall assignment which included both the COVID-19 unit and the rest of C-Hall that were COVID-19 negative. On 8/9/21 at 11:50 a.m., V5 was in the common dining room passing trays and assisting residents with their food. On 8/9/21 at 12:00 p.m., R83 was sitting in the dining room at a table with peers and did not have a face covering/mask on R83's face. On 8/9/21 at 2:15 p.m., V2 (Director of Nursing/Infection Preventionist) stated R50 tested positive for COVID-19 on 7/30/21. V2 stated R8's positive COVID-19 test results came this morning (8/9/21). V2 stated R83 is quarantined due to being R8's roommate. V2 stated R83 was left in the same room (on the COVID-19 unit) and R8 was moved to another room on the COVID-19 unit. R8's SARS-COV-2 PCR Test Report dated 8/8/21, documents R8 was positive for COVID-19. On 8/10/21 at 8:40 a.m., V6 CNA (Certified Nurse	S9999		

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Aide) was passing breakfast trays to R50 and R8. V6 was wearing an N95 mask, gloves, gown, and face shield. V6 went from R50's room to R8's room to provide care without changing gloves, gown, mask, or face shield.

On 8/10/21 at 8:40 a.m., the plastic barrier at the entrance of the COVID-19 unit had a large opening.

On 8/10/21 at 8:47 a.m., V4 (Licensed Practical Nurse) entered the COVID-19 unit wearing an N95 mask, gown, gloves and eye protection. V4 went into R50's room to give him his medications. V4 then came out of R50's room and entered R83's room to give her a breakfast tray without changing gloves, gown, mask, and eye protection. V4 then removed her gown and gloves and exited the COVID-19 unit. V4 looked for hand sanitizer on the PPE container but there was none present. V4 then reached into her shirt pocket and grabbed a small bottle of hand sanitizer and sanitized her hands. V4 then walked back to the nurses' station in the resident dining room area and started passing medication to other residents. On 8/9/21 at 8:52 a.m., V4 stated there are no dedicated staff for the COVID-19 unit. V4 stated we just change gloves and gowns and sanitize hands when leaving the COVID-19 unit.

On 8/10/21 at 8:51 a.m., V6 removed and disposed her gown and gloves and then exited the COVID-19 unit. V6 was unable to locate hand sanitizer at the PPE station. V6 stated, "I needed (V4) to wait on me so I could use her hand sanitizer." V6 then walked down the C-Hall into the common area, went up to a staff member and had a conversation and then went to the sink behind the nurse's station to wash her hands. V6

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S9999	Continued From page 7 stated that V6 was not working the C-Hall today but was just helping get breakfast trays passed. V6 stated the facility does not have staff designated to work the COVID-19 unit. On 8/10/21 at 2:20 p.m., the plastic barrier at the entrance of the COVID-19 unit continued to have a large opening. On 8/10/21 at 2:25 p.m., V4 (Licensed Practical Nurse) stated R83 is quarantined on the COVID-19 unit due to being R8's roommate at the time R8 tested positive for COVID-19 (8/9/21). V4 stated R83 will remain on the COVID-19 unit for 14 days. V4 stated the facility does not have designated staff for the COVID-19 unit. On 8/10/21 at 1:57 p.m., V2 (Director of Nursing) stated the facility does not have enough staff to have dedicated staff on the COVID-19 unit. V2 stated the facility does not have a written plan to designate an area for PUIs (Person Under Investigation) and V2 was unable to verbalize the current CDC guidance on the difference between housing COVID-19 residents and PUIs. V2 stated R83 is quarantined due to being R8's roommate who tested positive for COVID-19 on 8/9/21. V2 stated R83 will be quarantined for 14 days and then tested for COVID-19 prior to discharging her from quarantine. V2 stated the staff should be changing their PPE and washing their hands when going from one resident to another in the COVID-19 unit and when leaving the COVID-19 unit. V2 stated there is supposed to be a bottle of hand sanitizer just outside of the COVID-19 unit and had no knowledge as to why there was no sanitizer for staff to use when leaving the COVID-19 unit. V2 stated the staff wear re-usable face shields and those should be disinfected	S9999		

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when leaving the COVID-19 unit. V2 stated the staff should also be changing into a clean mask when leaving the COVID-19 unit and going into non-COVID areas of the building. V2 stated the plastic barrier at the COVID-19-unit entrance should always remain intact and closed. V2 stated she was not aware of the plastic barrier having a large opening.

On 8/11/21 at 9:09 a.m., R8 was behind the plastic barrier for COVID-19 isolation. V5 CNA (Certified Nurse Aide) came down the hall as R8 was trying to break through the plastic barrier because she heard it was time to smoke. R8 required much encouragement from V5 to keep R8 behind the plastic barrier. V5 stated that R8 is blind and needs help to go outside to smoke. V5 stated V5 was the CNA for the COVID isolation residents, R53, R8 and R83, and also for the two male residents in non-isolation room on the same hall. V5 stated that both those residents, in the non-isolation rooms are dependent on staff for cares and V5 had to assist one of those residents (R53) with eating breakfast this morning.

On 8/11/21 at 9:15a.m., V14 CNA walked down to the COVID barrier and stated to V5 CNA that all three residents, R50, R8, and R83, should not go out together to smoke. But V5 CNA took all three outside together to smoke. R50 was able to go out without V5's assistance but R8 and R83 needed V5's assistance. V5 had to push R83's wheelchair out the door and then V5 held onto R8 while R8 walked outside. V14 stated that R83 was R8's roommate at the time R8 tested COVID positive, but R83 is not currently positive, just in quarantine with the two COVID positive residents. V14 stated that the facility is awaiting another COVID test result for R83.

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On 8/11/21 at 9:25 a.m., V5 CNA walked R8 back to her room after smoking. A large gap was noted in the plastic barrier at the COVID unit the entire time V5 was working in the isolation area. V5 wore the same gown, gloves, mask, and face shield to assist R83 as she had worn to assist R8.

On 8/11/21 at 9:30a.m., V5 removed her gown and gloves, exited the COVID isolation area then removed her face shield and placed it on top of the isolation cart located outside the plastic barrier area where non-isolation residents reside, applied a new gown and gloves, reapplied the shield then went back into isolation, into R8's room to see what R8 needed. During all observations, both R83 and R8 had their doors open to the hall. V5 removed her soiled gown and gloves, exited the isolation area, then went back in the isolation area again without a gown to remove her shoe coverings. V5 used hand sanitizer and then exited isolation to get a washcloth for R8. V5 then reapplied new shoe covers. After V5 exited the isolation area, she kept taking her N95 mask off and on while touching the mask with the palm of her hand. V5 wore the same mask and face shield down the non-isolation hall without sanitizing the face shield or changing her mask.

On 8/11/21 at 10:12a.m., V5 CNA was walking all around the dining room with multiple residents seated in the dining room. V5 was observed touching her face shield and mask, which she had worn in the COVID unit, to adjust them repeatedly and without performing hand hygiene.

On 8/11/21 at 10:31a.m., V5 returned to the isolation wing, applied a gown, gloves, shoe covers, was still wearing the same face shield and mask, then entered the isolation area. V5

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removed a biohazard bag from the isolation area, placed it on the floor outside the isolation unit, then removed her gown, gloves, and shoe covers. V5 continued to wear the same face shield and mask.

On 8/11/21 at 1:19 p.m., V9 (Local Health Department Infectious Disease Specialist) stated V9 has not received any phone calls or emails from the facility asking for guidance on room placement for residents with COVID-19 or PUIs. V9 stated the PUIs should not be residing on the COVID unit. V9 stated the PUIs need to be quarantined in a different area. V9 stated the facility is also required to have dedicated staff for the COVID-19 unit. V9 stated the facility has not contacted V9 for guidance or to report a staffing crisis. V9 stated the cross contamination from R83 and not having dedicated staff on the COVID-19 unit, has potentially exposed all staff and residents.

The Facility Nursing 24-hour Daily Staffing sheets dated 7/30/21 through 8/9/21, do not document designated staff for the COVID-19 unit.

The Centers for Medicare and Medicaid Services, Resident Census and Condition of Residents, completed by V11 (Minimum Data Set Coordinator) on 8/10/21, documents there are 98 residents residing in the facility.

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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.

Section 300.3240 Abuse and Neglect

f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy

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and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide supervision to prevent resident to resident physical abuse for one of four residents (R53) reviewed for abuse in the sample of 44. These failures resulted in R53 being hit in the face on two different occasions, 6/16/21 and 7/18/21, subsequently sustaining an abrasion and bruised left eye.

Findings include:

The Facility's Abuse Prevention Program Facility Policy dated 2/24/21, documents, "Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment."

R53's current computerized medical record, documents R53 was admitted to the facility on 7/1/19 with diagnoses which include, Huntington's Disease, Extrapyramidal and Movement Disorder, and Schizophrenia.

R53's Minimum Data Set assessment dated 6/15/21, documents R53 has moderately impaired cognition and Delusions, and requires limited assistance with ambulation with no mobility devices.

R53's Care Plan dated 6/22/21, documents R53 has, "Very poor impulse control and psychotic unpredictable behaviors" with interventions that

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 ______	08/12/2021

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
S9999	Continued From page 13	S9999		

include, "Cue, reorient, and supervise as needed."

R53's Incident/Accident Report dated 6/16/21 at 5:40 p.m., documents R53 was observed taking food from a peer's (R17) dinner tray and (R17) struck R53 in the face causing an abrasion under R53's left eye.

R53's Care Plan dated 6/17/21, documents to redirect R53 away from peers' food trays, get him more food, and if combative to remove him from the dining room to a quiet place.

R53's Incident/Accident Report dated 7/18/21 at 11:35 a.m., documents R53 walked up and drank another resident's (R65) drink during lunch and R65 struck R53 in the left eye with no apparent injuries.

On 8/9/21 at 10:45 a.m., R53 was out on the smoking patio smoking a cigarette with a large group of his peers.

On 8/10/21 at 12:10 p.m., R53 was sitting at a dining room table with his peers eating lunch.

On 8/11/21 at 10:30 a.m., R53 was outside on the smoking patio with a large group of peers.

On 8/11/21 at 12:25 p.m., R53 was sitting in the dining room with his peers eating lunch.

On 8/11/21 at 1:15 p.m., R53 had a verbal and physical behavioral outburst in the middle of the dining room with peers sitting in the dining room all around him. R53 was screaming and hit a staff member in the head and pulled her hair. It took 4 staff members to re-direct R53 away from the dining room and peers and get him back to his

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S9999	Continued From page 14 room. On 8/11/21 at 11:30 a.m., V17 (Licensed Practical Nurse) stated she witnessed R17 hit R53 in the face on 6/16/21. V15 stated "(R53) ended up with a black (bruised) eye. I could not get to (R53) fast enough to stop (R17) from hitting him." On 8/11/21 at 12:31 p.m., V10 (Case Manager), stated R53 was involved in two physical abuse incidents where R53 was struck by other residents on 6/16/21 and 7/18/21. V10 stated the incident on 6/16/21 resulted in V9 having a "black eye for a few days." (B)	S9999		