STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007272	A. BUILDING: _____ B. WING _____	C 06/26/2022

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) COMPLETE DATE
S 000	Initial Comments Complaint 2224778/IL148125	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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. Restorative measures shall include, at a minimum, the following procedures: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to prevent a resident injury by not keeping the bed in low position before leaving a resident unattended for one resident (R2) reviewed for falls. This failure resulted in R2 falling out of bed, hitting his head causing decreased level of consciousness/unresponsiveness, a four cm (centimeter) hematoma on his forehead with a two cm laceration requiring four staples, requiring hospitalization for five days with a primary diagnosis of Traumatic Subarachnoid	S9999		

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S9999	Continued From page 2 Hemorrhage (brain bleeding) of the frontal lobe. Findings include: The facility's Fall Prevention policy (undated), states, "It is the policy of this facility to prevent falls and serious injury outcomes by recognizing multi-factorial risks and causes, and institute recommendations for fall prevention and management consistent with clinical practice guidelines and standards of care." R2's Minimum Data Set assessment dated 3/22/22, documents R2 requires total assistance of two staff for bed mobility and transfers. R2's Incident Report dated 4/2/22, documents R2 fell out of bed. R2's Care Plan last revised on 6/21/22, documents R2 has a history of falling out of his bed and wheelchair (prior to 5/20/22). R2's Incident/Accident Report dated 5/20/22 at 1:40 p.m., documents R2 fell out of his bed and hit his left forehead on the floor causing a 2 cm laceration, 4 cm hematoma and decreased level of consciousness. This same report documents R2 was sent to the local hospital. R2's Incident Investigation Report dated 5/20/22 at 1:40 p.m., documents, "(V8/CNA) changing (R2) soiled depend, noted stool on sheet. (V8) Stepped into hallway to get a clean sheet. Upon entering (R2's) room, (V8) witnessed (R2) roll off his bed and onto floor. Hit head on floor. Action Plan: Ensure that bed is in the lowest possible position before leaving bedside." R2's Hospital History and Physical dated 5/20/22,	S9999		

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S9999	Continued From page 3 documents images from the Computed Tomography (CT) dated 5/20/22, shows a Traumatic Subarachnoid Hemorrhage (brain bleeding) of the frontal lobe due to a fall from (R2's) bed. R2's CT scan dated 5/20/22, documents R2 had left frontal lobe acute Subarachnoid hemorrhage. R2's Hospital Progress Note dated 5/25/22, documents R2 was hospitalized for 5 days after being admitted for "Traumatic Intracerebral Hemorrhage (HCC)." This same note states, "Plan to return (R2 to the facility) with Hospice, anticipate discharge (5/26/22); transitioned to comfort-focused care today." R2's Progress Note dated 5/26/2022 at 7:20 p.m., documents R2 was readmitted from the hospital; R2 was non-verbal with, "eyes open looking around"; 4 staples to left forehead; R2 is "100% dependent for all cares"; R2 assessed by Hospice for admission. On 6/25/22 at 7:02 p.m., V8 stated, "I was changing (R2) and he messed his sheets with (feces). I left him in his bed, in high position, to go and get clean sheets. When I came back in the room he was falling out of the bed. (R2) was on the floor, face down with blood coming out of his head. I didn't move (R2) and called the nurse for help. I was given a counseling form (by administration) for leaving (R2's) bed up in a high position and leaving him unattended. I know now to always lower the bed before leaving a resident or call for assistance." On 6/25/22 at 6:34 p.m., V1 (Administration) stated that immediately after R2's fall on 5/20/22, V8 (CNA/Certified Nurse Aide) was reprimanded.	S9999		

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S9999	Continued From page 4 V1 stated V8 left R2 unattended with the bed in the highest position to go get clean linens in the hall. V1 stated when V8 walked back into the room, R2 was falling out of bed and landed face down causing head trauma and a brain bleed. V1 stated R2 did have a significant injury from that fall on 5/20/22. V1 stated the fall resulted in R2 becoming unresponsive and having a laceration to his head requiring staples, being hospitalized until returning to the facility on 5/26/22, and admitted to Hospice care. V1 stated V8 and all nursing staff were educated on not leaving residents unattended without lowering the bed and putting any safety interventions required in place. V1 stated the staff may even call for extra assistance if needed rather than to leave a resident at risk for injury. (A)	S9999		