Illimois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6007272 B. WING 07/20/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3520 NORTH ROCHELLE SHARON HEALTH CARE WILLOWS **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Annual Health and Licensure Survey S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.690b)c) 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 300.690 Incidents and Accidents The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. The facility shall, by fax or phone, notify c) the Regional Office within 24 hours after each Attachment A reportable incident or accident. If a reportable Statement of Licensure Violations incident or accident results in the death of a

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6007272	B. WING		07/2	07/20/2022	
NAME OF PROVIDER OR SUPPLIER STREET A			DDRESS, CITY, STATE, ZIP CODE				
SHARON	I HEALTH CARE WILL	-0113	RTH ROCHEL IL 61604	LLE .			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLET DATE	
	Continued From page 1  resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.  This REQUIREMENT was not met as evidenced by:  Based on interview and record review, the facility failed to notify State Agency of serious resident injury for one (R110) resident reviewed for accidents.  Findings include:  The facility's Incidents-Accidents policy, updated 6-16-22, documents, "Definitions: Incident- Any		S9999	DEFICIENCY)		DATE	
	occurrence that coule great emotional upse Notify the D.O.N. (Di designee and the ad- incident/accident. In	d result in physical harm or et to a resident. Procedure: 2. rector of Nursing) or					
i c	documents the follow unwitnessed fall at 7: door. R110 was origin became weak and no Ambulance Service)	e, dated 5-3-22 at 8:54pm ving: R110 had an 50pm in front of the patio hally verbal post fall then on-responsive. (Local called at 8:10pm and					
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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED IL6007272 B. WING 07/20/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3520 NORTH ROCHELLE SHARON HEALTH CARE WILLOWS **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 resident transported with airway in place at 8:30pm. R110's Progress Note, dated 5-3-22, at 9:30pm documents that upon speaking to staff at the hospital, R110 possibly had a bleed in the right side of his brain. R110 was also being intubated at the time and remained unresponsive. On 7-20-22, at 8:56 am, V1 (Administrator) confirmed that V1 did not report R110's fall with injury and stated, "In hindsight I probably should have errored on the side of reporting it after getting more information about (R110's) condition." (B)

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