Illinois D	epartment of Public	Health			FORM	APPROVE	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6007272	B. WING			C 27/2024	
	ROVIDER OR SUPPLIER	L		STATE, ZIP CODE		21/2024	
		3520 NO	RTH ROCHEI				
SHARON	HEALTH CARE WIL	LOWS PEORIA,	IL 61604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Investigation of Fac 11-08-2024/IL1807	cility Reported Incident of 92					
S9999	Final Observations		S9999				
	Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6)						
	Section 300.610 Resident Care Policies						
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall comp The written policies the facility and shal	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed					
	Section 300.1210 Nursing and Person	General Requirements for nal Care					
	care and services t practicable physica well-being of the re each resident's con plan. Adequate and care and personal of	shall provide the necessary o attain or maintain the highes I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident.					
	ment of Public Health	DER/SUPPLIER REPRESENTATIVE'S SIC		TITLE		(X6) DATE	
	cally Signed					12/23/24	
ATE FORM	1		6899 V	VMRJ11	lf continu	ation sheet 1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6007272	B. WING			C 27/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	CORRECTION ON SHOULD BE HE APPROPRIATE	
SHARON	I HEALTH CARE WILI	OWS	RTH ROCHEL IL 61604	LE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
S9999	Continued From pa	ge 1	S9999			
	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:					
	to assure that the re as free of accident nursing personnels	ry precautions shall be taken esidents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.				
	These Regulations	are not met as evidenced by:				
	failed to ensure res abuse did not occur reviewed for abuse failure resulted in R	and record review, the facility ident to resident physical r for two residents (R2, R3) in a sample of four. This 2 being transported to the ment; and R2 sustaining a				
	Findings include:					
		lude Dementia, Psychotic Disturbance, Anxiety, Bipolar pressive Disorder.				
		a Set/MDS Assessment dated R2 as cognitively intact.				
	verbal aggression t	Plan documents, "(R2) has had hat has escalated to physical on towards staff and peers."				
	R3's diagnoses incl Bipolar Type.	lude Schizoaffective Disorder				
	R3's Minimum Data	a Set/MDS dated 10/28/24				

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		IL6007272	B. WING			C 27/2024
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	•	
	I HEALTH CARE WIL	3520 NC				
		PEORIA	, IL 61604			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	documents R3 as o	cognitively intact.				
		Plan documents: "(R3) may be ve with peers at times."				
	Agency) for R2 and Description: On 11 on the ground on th physical altercation	and Final Reports to (State I R3 document, "Incident /8/24, (R2 and R3) were noted he outside patio engaged in a with one another. (R2) his hand, nose, and back of visible injuries."				
	documents V6 Cert stated that R8 said patio. V6 stated tha R2 in the face with	hation Report Dated 11/8/24 tified Nursing Assistant/CNA "fight" and she ran out to the at R3 was on top of R2 hitting a closed fist; and V6 stated V6 then stated that she did ted the fight.				
	also documents, "(Nursing/ADON) wa smoking patio by th was noted on his ha help. R2 was assist assessed (R2) and laceration across th 1.0 cm laceration to Orders were given hospital for further contacted and gave	hation Report Dated 11/8/24 V2 Assistant Director of s alerted to the facility's South he staff; and once outside, (R2 ands and knees calling for ted up by staff and (V2) noted a 0.5 centimeter/cm he bridge of (R2's) nose and a to the back/center of his head. for (R2) to be sent to the evaluation. Police were e (R3) a choice of going to jail) was resistive to both, so the ail."	?)			
	documents: "(R2) s	nation Report Dated 11/8/24 aid (R3) pushed (R2) and just to the ground. (R2) didn't	t			

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Illinois D	epartment of Public	Health			FURIN	APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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SHARON	N HEALTH CARE WILL	OWS	RTH ROCHEL IL 61604	LE		
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S9999	Continued From pa	ge 3	S9999			
	"Diagnoses, Closed encounter; Assault. On 11/26/24 at 2:05 sent to the Emerge hospital after the 11 arrived back at the stated that the hosp nose, and it "still hu stated: "He's (R3) a gone." On 11/27/24 at 10:3 Assistant/CNA state	5pm, R2 stated that he was ncy Department at the local l/8/24 incident with R3 and facility the same day. R2 bital staff said he had a broken irts." At this same time, R2 a troublemaker; I am glad he's 80am, V6 Certified Nursing ed that on 11/8/24 she was				
	near the patio door that R2 and R3 wer altercation. V6 state intervene between residents. On 11/27/24 at 9:55 the physical alterca	g station; stated that (R8) was and shouted "fight". V6 stated e on the ground in a physical ed V6 immediately went to R2 and R3, separating the two 5am, V1 Administrator verified tion on 11/8/24 between R2 he local police were notified				
	Dated 6/3/24, docur committed to protect by anyone including staff, other resident staff from other age the individual, famil guardians., friends, Physical Abuse is th resident that occurs	e Prevention Program Policy ments: "This facility is cting our residents from abuse g, but not limited to, facility is, consultants, volunteers, encies providing services to				

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If continuation sheet 4 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		
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HARON	I HEALTH CARE WIL		ORTH ROCHELI , IL 61604	LE		
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S9999	Continued From pa	age 4	S9999			
		(B)				
<u> </u>	tment of Public Health					

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