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	IL6007272	A. BUILDING: _____ B. WING _____	C 06/17/2025

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SHARON HEALTH CARE WILLOWS	3520 NORTH ROCHELLE PEORIA, IL 61604

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S 000	Initial Comments Complaint Investigations: 2524535/IL192807 2525404/IL194542 Investigation of Facility Reported Incidents of: 05-12-2025/IL193048 05-18-2025/IL193050	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.1210d)6) 300.3240e) 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	S9999		

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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.

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

e) 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 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 Regulations are not met as evidenced by:

Based on interview, observation and record review, the facility failed to protect residents from episodes of physical abuse occurring for three of ten residents (R1, R4, and R10) reviewed for abuse in the sample of 12. This failure resulted in R1 being pushed to the ground by R2 causing R1 to experience excruciating pain to her right wrist

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and sustaining a right wrist fracture.

Findings include:

1. R1's computerized Medical Record documents that R1 is a 62-year-old female that admitted to the facility on 4/4/25 with diagnoses which included Major Depressive Disorder, Unspecified Psychosis Not Due to A Substance or Known Physiological Condition, Post-Traumatic Stress Disorder, Unspecified, Borderline Personality Disorder, Extrapyramidal and Movement Disorder, Unspecified.

R1's MDS (Minimum Data Set) Assessment, dated 4/25/25, documents R1 is cognitively intact.

R4's computerized Medical Record documents that R4 is a 70-year-old female that admitted to the facility on 2/17/22 with diagnoses which included Schizoaffective Disorder, Borderline Personality Disorder, and Anxiety.

R4's MDS Assessment, dated 4/2/25, documents R4 is moderately cognitively impaired.

The Incident Investigation Report, dated 5/12/25, documents "On 5/12/25 at 3:15 PM in the North dining room, (R1) approached the table where (R4) was and grabbed (R4's) belongings. (R4) stood up and grabbed her stuff back. (R1) then pushed (R4) and (R4) hit (R1) 2X (two times) in the face (with) closed fist. Residents were separated by staff and first aid administered. (R1) sustained a superficial scratch above her R (right) eye and it was red."

Investigation interviews, dated 5/12/25, documents R7 was a witness to the incident on 5/12/25 between R1 and R4.

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On 6/13/25 at 1:45 PM R7 stated, "I witnessed around a month ago (R1) trying to take (R4's) things off the table in the dining room. (R4) was upset because they were her things, so she tried to grab them back and (R1) pushed (R4). (R4) then got mad and hit (R1) twice in the face."

On 6/13/25 at 1:51 PM R4 was sitting at the dining room table on north side. R4 stated, "(R1) was trying to take my things from the table a while back and she ended up shoving me, so I hit (R1) twice in the face."

2. R2's computerized Medical Record documents that R2 is a 65-year-old male that admitted to the facility on 11/29/23 with diagnoses which included Wernicke's Encephalopathy, Psychotic Disorder with Delusions due To Known Physiological Condition, Major Depressive Disorder, Recurrent, In Partial Remission, and Generalized Anxiety Disorder.

R2's MDS Assessment, dated 5/14/25, documents R2 is moderately cognitively impaired.

R3's MDS Assessment, dated 3/4/25, documents R3 is moderately cognitively impaired.

The Incident Investigation Report dated 5/18/25 documents "On 5/18/25 at 12:20 PM in the North Dining Room, (R1) was pushed by (R2) and fell to the ground. (R3) then approached (R2) and grabbed (R2's) shoulders to stop (R2).

The Incident/Accident Report dated 5/18/25 at 12:20 PM, documents "(R1) approached peer (R2) attempting to retrieve (R2's) snacks. (R1) grabs snacks causing her (R1) and the peer (R2) to begin wrestling the snacks out of (R1's) hands.

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Ultimately peer (R2) ended up pushing (R1) down to the ground, where (R1) landed on her buttocks."

Investigation Interviews, dated 5/18/25, documents R3 was a witness to the incident on 5/18/25 between R1 and R2. This same interview documents R3 stated, "I tried to stop (R2) from hitting (R1)."

Investigation Interviews, dated 5/18/25, documents V15/RN (Registered Nurse) was a witness to the incident on 5/18/25 between R1, R2, and R3. This same interview documents V15 stated, "I saw (R1) grab (R2's) snack on the floor. Both residents (R1 and R2) then started wrestling the snack out of each other's hands. Then (R2) pushed (R1) making (R1) fall on her buttocks. Both residents then separated then (R3) approached (R2) and grabbed (R2) by his arm/shoulder that seems like (R3) is stopping (R2) from what he (R2) had done (to R1) then both residents (R2 and R3) were separated."

R1's Progress Note, dated 5/18/25 and signed by V12/RN, documents "(R1) approached peer (R2) attempting to retrieve his snacks. (R1) grabs snacks causing her and the peer (R2) to begin wrestling the snacks out of (R1) hands. Ultimately peer (R2) ended up pushing (R1) to the ground, where she landed on her bottom."

R1's Progress Note, dated 5/19/25 and signed by V17/LPN (Licensed Practical Nurse) documents "Nurse noted (R1's) right hand and wrist to be swollen and (R1's) complaint of pain. When asked what happened, (R1) states she fell yesterday. (V16/R1's Primary Physician) notified and new order received to obtain a right-hand x-ray with 3 (three) views."

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S9999	Continued From page 5 R1's Right Hand X-Ray Report, dated 5/20/25, documents "Impressions: Displaced fracture distal radial metaphysis." On 6/14/25 at 10:14 AM V1/Administrator verified R1's right wrist fracture was caused from R2 pushing R1 down on 5/18/25. On 6/14/25 at 11:25 AM V15/RN stated, "I was in the dining room on North Side passing medications. I witnessed (R1) and (R2) fighting over (R2's) snacks. (R1) and (R2) both were tugging on the snack at the same time, then when they both let go of the snack, (R2) pushed (R1) down to the ground. (R1) landed on her buttocks. I immediately separated them." On 6/14/25 at 1:52 PM R1 was sitting in her room on her bed. R1's right wrist was observed to have a brace on. R1 stated her wrist hurts "bad." 3. The Incident Investigation Report dated 5/22/25, documents "On 5/22/25 at 2:55 PM in the North main Dining Room, (R2) pushed (R1), who fell to the ground. (R2) stated (R1) went towards his cup so he (R2) pushed her (R1). Nursing assessed and no injuries were noted." Investigation Interviews, dated 5/22/25, documents V13/CNA (Certified Nursing Assistant) was a witness to the incident on 5/22/25 between R1 and R2. This same interview documents V13 stated that V13 was walking through the dining room area when V13 witnessed R2 pushed R1 down to the floor. Investigation Interviews, dated 5/22/25, of R2 documents that R2 stated R1 went for his cup so R2 pushed R1 so R1 could not get it (the cup).	S9999		

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On 6/14/25 at 10:58 AM V13/CNA stated, "I was in the North Side dining room. (R1) walked up to (R2) and grabbed (R2's) cup, so as I walked by, I witnessed (R2) push (R1) down."

The facility's Abuse Prevention Program Facility Policy, dated 6/5/25, documents "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. The facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction on injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment."

4. R10's computerized Medical Record documents that R10 is a 66-year-old female that admitted to the facility on 11/21/23 with diagnoses

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which included Schizoaffective Disorder, Bipolar Type, Post Traumatic Stress Disorder, Unspecified.

R10's MDS (Minimum Data Set) assessment dated 2/20/24 documents a BIMS (Brief Interview for Mental Status) of 14, indicating (cognition intact). R10 has no extremity impairment, required supervision for eating, is independent for all activities of daily living, bed mobility and transfers. R10 has Delusions, verbal behaviors directed towards others and rejects care.

R12's computerized Medical Record documents that R12 is a 71-year-old male that admitted to the facility on 2/8/24 with diagnoses which included Alzheimer's Disease, Unspecified, Generalized Anxiety Disorder, Paranoid Schizophrenia, and Unspecified Dementia.

R12's MDS (Minimum Data Set) assessment dated 2/14/24 documents a BIMS (Brief Interview for Mental Status) of 9, indicating (moderate cognitive impairment). R1 has no extremity impairment and is independent for all activities of daily living, bed mobility and transfers. R12 has Delusions, verbal and physical behaviors directed towards others.

R10's Incident/Accident Report dated 4/4/24 at 9:28 PM, documents "(R10) was in the wheelchair on F Hallway, peer (R12) came out of his room and hit (R10) on the left jaw. No apparent injuries noted."

R12's Incident/Accident Report dated 4/4/24 at 9:28 PM, documents "(R12) noted with agitation, (R12) hit the female (R10) on the jaw."

The Incident Investigation Report dated 4/4/24

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documents "On 4/4/24 at 9:30 PM on F-hall (R12) hit (R10) with a closed fist to the left jaw. No initial injuries were noted.

R10's Nursing Note dated 4/4/24 at 9:40 PM, documents "(R10) was in her wheelchair in the hallway, male peer (R12) came out of his room yelling and screaming, walked down to (R10) and hit (R10) on the left jaw with closed fist. No apparent injuries, (R10) denies pain or discomfort at this time."

The Witness Statements taken by V1/Administrator dated 4/5/25 at 12:25 PM, document "(R10) stated she was passing by and (R12) hit her on the left jaw." "Unable to interview (R12)." "(V20/Certified Nursing Assistant/CNA) stated that (R10) was passing in the hallway and (R12) out of nowhere started yelling and hit (R10) with a closed fist to the jaw." "(V11/CNA) stated (R12) and (R10) were just passing each other and (R12) hit (R10) before staff could intervene."

R10 refused to be interviewed and R12 was unable to answer question appropriately. On 6/16/25 at 11:14 AM V1/Administrator verified that R12 did hit R10 in the jaw on 4/4/24.

(A)
Statement of Licensure Violations 2 of 2:
300.610a)
300.1210b)
300.1210d)6)

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

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S9999	Continued From page 9 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 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. These Regulations are not met as evidenced by: Based on interview and record review the facility failed to prevent a fall for one resident (R5) of 3 residents reviewed for falls in the sample of 12.	S9999		

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This failure resulted in R5 sustaining a fractured femur, causing R5 significant pain and required surgery.

Findings include:

R5's computerized Medical Record documents that R5 is a 62-year-old female that admitted to the facility on 1/30/23 with diagnoses which included Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Metabolic Encephalopathy, Disorientation, Acquired Absence of Kidney, and Presence of Right Artificial Shoulder Joint. On 5/8/25 the diagnosis of Unspecified Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing was added.

R5's MDS (Minimum Data Set) assessment dated 3/25/25 documents a BIMS (Brief Interview for Mental Status) of 13, indicating (cognition intact). R1 has delusions, verbal abuse and other behaviors not towards others. R5 has an upper extremity impairment on one side, requires supervision for all activities of daily living/toileting, is independent with bed mobility, and is occasionally incontinent.

R5's Care Plan documents "(R5) is at risk for falls, (R5) ambulates independently but has a history of wheelchair use."

On 6/13/25 at 10:12 AM R5 was sitting in her wheelchair at a table located in the north side dining room. R5 was dressed and groomed appropriately and had non-skid shoes on. R5 stated "When I fell and broke my leg, I was trying to go to the bathroom in my room. I only have one kidney so as soon when I have to go to the bathroom I have to go. I went to stand up to go to the bathroom and I slipped on water that was on

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the floor, fell and hurt my right leg. I went to the hospital after that and had surgery." R5 then lifted her right pant leg and showed where R5 had surgery on her right leg.

R5's Fall Screening dated 4/5/25 at 11:20 PM, documents that R5 was walking, slipped on a wet surface and lost her balance.

The Witness Statement given by V10/Certified Nursing Assistant/CNA dated 4/5/25 at 11:20 PM, documents "(V10/CNA) stated she was walking by (R5's) room and (R5) was in bed. (V10) noticed a large puddle on her (R5's) floor. (V10) went to go get something to clean up the floor and (R5) must have stood up while (V10) was gone. When (V10) returned (R5) was on the floor and couldn't move her leg."

The Witness Statement given by R5 dated 4/5/25 at 11:20 PM, documents that R5 stated she slipped when R5 got up to use the bathroom.

R5's Incident Investigation Report dated 4/5/25 documents "Potential Contributing Factors: Wet floor, (R5) is impulsive - did not wait for staff to clean up floor." "On 4/5/25 at 11:20 PM in (R5's) room (R5) was noted by staff lying on the floor. Upon assessment (R5) was unable to bend her right leg without significant pain and (R5) was unable to bear weight. (R5) stated she lost her balance getting up to go to the bathroom. Results from the hospital indicated (R5) fractured her femur."

R5's Nursing Note dated 4/6/25 at 4:36 AM, documents "(R5) was observed by this nurse lying on the floor in her bedroom in a supine position after being summoned by direct care staff. Further assessment indicates that (R5) is

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unable to bend her right leg without significant pain which renders her unable to attempt to bear weight." R5 was sent to the Emergency Department for evaluation and treatment.

R5's Hospital X-ray Report dated 4/6/25 documents "Impression: Acute comminuted and displaced distal femur fracture extending to the articular surface of the knee." "Findings: Acute comminuted fractures involving the distal femoral diaphysis and extending to the articular surface of the trochlea. One of the dominant fracture lines extends from the medial aspect of the metaphysis obliquely towards the trochlea with a small fracture line extending into the lateral femoral condyle. A second dominant fracture line extends obliquely across the diaphysis to the metaphysis. The distal fracture fragment is displaced posteriorly by half a shaft width. There is also impaction of the fracture fragments. Moderate-sized lipohemarthrosis. Edema in the musculature surrounding the fracture."

R5's Hospital Discharge Summary dated 4/10/25 documents that R5 was in the hospital from 4/5/25 to 4/10/25. R5 was admitted to the hospital on 4/5/25 from (the facility) due to a ground level fall resulting in a right "Femur fracture." "(R5) was having right knee pain and found to have distal right femur fracture. (R5) was admitted for further management. On exam (R5) does have right thigh tenderness and knee tenderness. X-ray of the right leg shows distal femur fracture. Acute commuted and displaced distal femur fracture extending to the articular surface of the knee. (R5) had an ORIF (Open Reduction and Internal Fixation) surgery on 4/6/25."

On 6/13/25 at 12:37 PM, V10/CNA stated "I walked past (R5's) room and saw there was

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 06/17/2025

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
S9999	Continued From page 13	S9999		

water all over (R5's) floor. (R5) had a large cup that must have spilled. I don't know how long the water had been there. (R5) was in her bed that was in a low position. When (R5) saw me come into the room (R5) started talking about vaping (using electronic cigarettes) and rolling in bed like she was trying to get up. (R5) gets adamant about when she wants to vape (smoke). I told (R5) to stay in bed and not to get up because there was water on the floor. (R5) was still trying to get up but (R5) needs help to get up from the low bed so I didn't think (R5) could get up. I went through the bathroom that was between (R5's) room and another resident's room to get some extra pads in the other room to absorb the water. Before I got back to the room (R5) had got up and fell. The other resident was talking to me, but I was only gone for a few minutes. I kept telling (R5) not to get up. It depends on (R5's) mood if she listens or not." V10 was asked if she thought she should have done anything different. V10 stated "I would have had someone stay with (R5)."

On 6/17/25 at 2:45 PM, V1/Administrator verified that R5 fractured her femur when R5 fell. V1 stated "I talked to (V10/CNA) about (R5's) fall and told (V10) that she should have stayed with (R5) and put the call light on until someone came to clean up the water so (R5) would not have got up and fell."

The Fall Policy dated 6/5/25 documents "It is the policy of this facility to prevent falls and serious injury outcomes by recognizing multi-factional risk and causes, and institute recommendations for falls prevention and management consist with clinical practice guidelines and standards of care. Nursing Care Strategies General safety precautions and fall prevention measures that

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S9999	Continued From page 14 apply to all patients: Assess the patient care environment routinely for extrinsic risk factors and institute appropriate corrective action." (A)	S9999		