STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E888	A. BUILDING _____ B. WING _____	10/08/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE WILLOWS	3520 NORTH ROCHELLE PEORIA, IL 61604

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F9999	FINAL OBSERVATIONS Licensure 300.610a) 300.1210a)	F9999		

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F9999	Continued From page 13 300.1210b)3) 300.3240a) The facility's written policies and procedures shall be followed in the operation of the facility. 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. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT NEGLECT A RESIDENT. This is evidenced by the following: Based on observations, interviews and record review the facility failed to follow their own policy for assessing and monitoring 1 of 1 residents, (R 1) that made suicidal statements. The facility did not change R1's pass status and he was allowed to leave the facility unsupervised. R1 walked in front of a car and was killed. Findings include: R1 was a 48 year old male resident with a diagnosis of Schizoaffective Disorder, Depression, and OCD (Obsessive Compulsive	F9999		

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F9999	Continued From page 14	F9999		

Disorder). MDS (Minimum Data Set) dated 8/25/04 under Cognitive Skills For Daily Decision-Making, R1 was assessed as "moderately impaired". Psychiatric Assessment dated 7/17/04 states: "This individual has apparently had psychiatric care for many years and has full-blown and fixed, grandiose delusions. Because of his psychosis, he could not function outside a structured program and he is appropriately placed at (facility)".

Telephone interview with Z1 on 9/30/04 at 3:05 PM states the following: "I was driving on Richwoods back home after being at grocery store. I saw the resident (R1) from a distance on the opposite side of the street just standing there. I paused to let him pass. He took one step out and back. I proceeded to drive again. He repeated this 3 times. I was going 25-30 miles per hour, he was just standing there watching me, then leaped out in front of me head first".

Review of ILLINOIS TRAFFIC CRASH REPORT by Peoria Police Department dated 9/24/04 documents a motor vehicle accident involving Z1 (driver of the vehicle) and pedestrian, R1 struck by Z1's vehicle on 9/23/04 at 12:36 PM. The report corroborates Z1's account of the accident that killed R1. The report also documents 2 other witnesses to the accident. The second witness was the front passenger of Z1's vehicle. Her account reflects Z1's statement. The third witness was the driver of another on-coming vehicle. Witness 3 states in the report, "The pedestrian (R1) bent over like a bull and ran in front of Z1's vehicle when it began to move forward again".

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F9999	Continued From page 15 In a written statement and interview by E5, Rehab Aide on 9/28/04 at 10:25 AM she states: "(R1) came to my program for job application and role playing for job interviews. I gave him a ditto to do. He was very jittery and couldn't focus on ditto. I went over the ditto verbally. I said to (R1) 'if there is something wrong you can talk to me about it?' (R1) said, 'I am suicidal'. We talked for next 40 minutes and he stated, 'I am having suicidal thoughts'. (R1) talked about his job in the kitchen and being upset that they switched him from working in the kitchen to cleaning the dining room. (R1) talked about being bored and upset that softball was ending. (R1) didn't know what he would do over the winter. (R1) wanted to leave AMA (Against Medical Advice) but said his sister is his guardian and couldn't. I talked to him up until about noon and had to go monitor lunch. He said, 'Can't we just stay here and talk'. I got security guard and he took (R1) back to the unit. I called (E6), RN (Registered Nurse) immediately and informed her of (R1) being suicidal. As of noon on Thursday (E6) told me he was on suicide watch when I saw her in the dining room. My understanding if someone is on suicide watch they should not go out into the community. At breakfast time the next morning 9/23/04 (R1) told me that he felt worse". Review of the facility's "SUICIDE /SELF ABUSE PRECAUTION PROCEDURE" states the following: "Immediately upon the report of a resident's act or voiced intent of suicide or self abuse, the Nurse on Duty shall be notified. The Nurse on Duty shall then notify the Director of Nursing and/ or Administrator for Precautionary Instructions.	F9999		

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F9999	Continued From page 16 PROCEDURE: A. Request that the resident not leave the facility without the accompaniment of staff or family. B. Encourage the resident not leave the facility without the accompaniment of staff or family. C. A designated staff member will be assigned to monitor the resident, and document their location and behavior on a Suicide Precaution Flowsheet. Any outstanding statements or behaviors, by the resident, will be reported to the Nurse immediately. D. The time periods being monitored on the Suicide Precaution/Flowsheet will be determined by the DON and/or Administrator with input from their staff. E. The above Procedure applies for a minimum of 24 hours, at which time a reassessment of the resident's condition will be made by the Administrative Team, with input from their staff. Interview and written statement by E1, Administrator on 9/29/04 at 3:30 PM and E3, DON (Director of Nursing) at 3:27 PM both state that they were never notified by anyone that R1 was suicidal or made a suicidal statement. Written statement and interview with E6, RN on 9/29/04 at 9:30 AM states: "I did tell (E5) that I placed him on suicide watch and pulled a sheet. This was an informal suicide watch. I told (E4), ADON (Assistant Director of Nursing) that I put out a sheet (15 minute checks). After I talked to him (R1), I didn't feel he was suicidal. I asked if he was OK. He said 'Yes'. I reported this to Psycho-Social, E7 or E8, PRSC (Psychiatric Rehabilitative Services Coordinator). Psycho-Social never came back to verify whether or not	F9999		

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they spoke to (R1). I don't know whether they actually spoke to him or not. If Psycho-Social changed his pass status he would not be able to leave. I just do an informal suicide watch for myself, it is not a facility policy. I never came out and specifically asked (R1) if he was suicidal. I handed (E4), ADON 15 minute check flow sheet to her along with his chart. I did not tell (E5) that the suicide watch flow sheet was informal".

In a later written statement and interview by E5 on 9/29/04 at 10:07 AM E5 states: "As far as I know I don't know whether or not anyone from nursing or Psycho-Social talked to (R1). No one came and talked to me about (R1) at any time after (R1) made the statements to me. I don't know anything about a formal versus informal suicide watch".

Interview with E7 PRSC's on 9/28/04 at 12:10 PM and E8 on 9/24/04 at 2:37 PM both stated that they were not aware of R1 being suicidal or making a suicidal statement.

Interview with E9 and E10, CNA's (Certified Nurse Aide) on 9/24/04 at 3:00 PM state: "CNA's signed off on suicide watch flow sheet at 11:30 AM on 9/23/04 when we saw him last. R1 signed out at 11:32 AM. He should have had his pass status changed to red and therefore would not have left the building".

Interview with R41 on 9/24/04 at 2:07 PM states the following: "He (R1) was quiet and kept to himself. Last thing he said to me was he wanted to kill himself. He told me this, this past Monday morning (9/20/04). I told him to talk to his PRSC. I don't know if he did. The facility knew about him

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being suicidal, and what I know they still let him get out by himself. I saw staff and security checking on him on 15 minute rounds".

Interview with E11, Security Guard/Doorman on 9/24/04 at 1:50 PM states that he was monitoring the front entrance door on Thursday (9/23/04) when R1 signed out. E11 states that R1 had a pass where he could go out. E11 denied knowing anything about R1 being on suicide precautions. Observation of the front entrance notes that the front door is unlocked with a staff member/security guard behind a glassed in reception area. This staff person has full view of the lobby and the front entrance. Residents were noted signing out of the building with this staff person present. The staff person at the door verifies each time a resident signs out by referring to a pass status book.

Interview with E12, LPN (Licensed Practical Nurse) on 9/29/04 at 3:10 PM states: "(R1) was on suicide watch the evening shift of 9/22/04. I was told by E6 in nurse report. I had heard he had written some kind of a note stating that he was going to kill himself. I wouldn't have allowed him out of the building".

Interview with E13, PRSC on 9/28/04 at 2:40 PM stated that he was R1's assigned PRSC. E13 denied knowing anything about R1 being suicidal or being on suicide watch 15 minute checks. E13 states that he did not talk to R1 on 9/23/04.

Interview with E4, ADON (Assistant Director of Nursing) on 9/24/04 at 2:25 PM states: "No he was not on suicide precautions. The nurse and aide talked to him. I saw him walking back from the store with a white sack the day he was killed".

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