

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Final Observations</p> <p>STATEMENT OF LICENSURE FINDINGS</p> <p>300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240b)</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 1</p> <p>restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)</p> <p>THESE REQUIREMENTS ARE NOT MET AS EVIDENCED BY: Based on observation, interview, and record review, the facility failed to provide supervision to</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 2</p> <p>prevent the elopement of one resident (R1) with severe cognitive deficits of three reviewed for supervision in a sample of five. R1 eloped from the facility on three different occasions without facility knowledge and was found without shoes on one occasion at a community residence.</p> <p>FINDINGS The facility's Wander Management Policy and Procedure, dated 9/19/14, states, "It is the policy of this facility to provide a safe, structured environment for residents who have been identified by the interdisciplinary care plan team as at risk for elopement due to cognitive impairment and accompanying exit-seeking behaviors...elopement is defined as leaving the facility premises without following the facility's policy and procedures for leave of absence." The facility's Resident Pass Policy, dated 9/19/14, states, "Each resident will be evaluated for community access at their initial MDS (Minimum Data Set) assessment...The Interdisciplinary Team will review and determine the individual's ability to access the community with or without staff/family. Based on the Interdisciplinary Team's decision (and with the Guardian's permission) a resident will be considered to have no pass (out with staff/family only) or will be given a pass which reflects the conditions of their pass status." R1's Physician orders, dated 10/2014, document R1 has diagnoses of Psychotic disorder, Traumatic Brain Injury, Seizure disorder, Mental Retardation, and Schizoaffective disorder.</p> <p>A Pass list report, no date available, documents R1 is only allowed to go on walks with staff as of 7/24/14.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 3</p> <p>R1's Brief Interview and Mental Status assessment, dated 10/9/14, documents R1 has a score of "five", indicating a severe cognitive impairment on a scale of 0-15.</p> <p>On 10/9/14 at 11:30 a.m., E10 (Traumatic Brain Injury Coordinator) stated, "(R1) was a traumatic brain injury at birth with severe development disorder. (R1) functions at a two year old level with poor safety awareness and poor memory. (R1) gets confused easily. (R1) has a history of attempting to leave the facility. Shortly after (R1) got here (R1) started making attempts to leave. (R1) has an electronic monitoring bracelet to alarm staff if (R1) leaves the facility, but there has been a few times staff have had to go out to the community to get (R1) when (R1's) gotten out. (R1) would not be safe for a pass to leave the building unattended because (R1) has no safety awareness of what is safe and what is not safe."</p> <p>R1's Clinical Mental Health Progress notes, dated 7/23/14 and written by E10, states, "Went on a walk in the neighborhood with (R1), per (R1's) request. (R1) would like to walk by self or with a peer. Throughout the walk, (R1) wanted to do various unsafe activities, for example, walk on the side of the highway, go into people's yards, visit a stranger's home, etc. We worked on defining what is safe vs. unsafe behavior. (R1) had a difficult time understanding what was appropriate."</p> <p>R1's Care plan, dated 9/2/14, states, "R1 has cognitive impairments, needs reminders, verbal cues and redirection. R1 has inattention and disorganized thinking. R1 is easily startled, which fluctuates. R1 has memory impairments, poor impulse control, poor insight, poor judgment, and poor independent living skills."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 4</p> <p>R1's Nurses notes, dated 8/4/14 at 9:00 p.m., documents R1 went for a walk with a peer and returned by the local police department, and ten minute checks were initiated.</p> <p>R1's Incident/Accident Report, dated 8/4/14 at 9 p.m., states, "(R1) went for a walk with a peer. Peer returned without (R1). Police returned (R1) to the facility at around 9 p.m. (R1) in no distress...Additional comments and/or steps taken to prevent recurrence: (R1) placed on 10 minute checks."</p> <p>On 10/14/14 at 2:45 p.m., R7 stated, "I went on a walk with (R1) just the one time back in August. (R1) ran off while we were walking. It happened while it was raining. The police brought (R1) back sometime after I got back."</p> <p>On 10/9/14 at 10:55 a.m., E11 (Licensed Practical Nurse) stated, "(R1) was out walking with (R7) on 8/4/14...(R7) returned to the facility prior to (R1). (R1) left prior to my arrival at 6:30 p.m. Medication pass is at 7:30-8 p.m. and that is when we recognized (R1) was missing. We started a search, including outside. We received a phone call from the sister facility next door stating they had a lady who didn't know who self was. As soon as our staff left to see if it was (R1), the police walked in with (R1). The police were not called when we noticed (R1) was missing. Following this incident we just continued 10 minute checks.</p> <p>R1's Nurses Notes, dated 9/2/14 at 12:00 p.m., states, "(R1) attempted to elope today. Intervened by staff. (R1) was brought back to the facility. Ten minute checks remain in effect."</p> <p>R1's Nurse's Notes, dated 9/21/14 at 12:08 p.m., states, "(R1) was going out on a walk with</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 5</p> <p>activities and tried to run away as soon as (R1) was outside."</p> <p>R1's Nurse's Notes, dated 9/28/14 at 10:45 a.m., states, "...Got out the front door and had to be retrieved by security...(R1) is still asking other residents to help (R1) get out a window or help (R1) get over the fence..." R1's Nurse's Notes On 9/30/14 at 10:24 p.m., states, "(R1) left out of a window on pass violation but was retrieved by security."</p> <p>On 10/9/14 at 3:30 p.m., E12 (Licensed Practical Nurse) stated, "It was 9/30/14 when I worked and we could not find (R1). The Certified Nursing Assistant (CNA) that was doing (R1's) ten minute checks said they could not find (R1) and (R1) got out of the window. I didn't fill out an Accident/Incident report because we got (R1) back and there was no injuries. This happens a lot where residents get out and we call the police and if they are ok I do not fill anything out or bother the Director of Nursing or Administrator with it. (R1) has taken off before, but we see (R1) and staff brings (R1) back. (R1) tries to get out all the time...(R1) doesn't have a pass to leave because (R1) will run away."</p> <p>R1's Incident/Accident report, dated 10/6/14 at 7:15 p.m., states, "(R6) states that (R1) climbed out of (R6's) window. Search is done and (R1) is not found in the facility or on the grounds."</p> <p>R1's Incident Report form, dated 10/6/14 at 7:15 p.m., states, "(R1) climbed out peer's window. Staff could not find (R1). Missing persons initiated. (R1) was found by staff and returned to the facility. Orders were received for direct admit to local hospital with increased psychosis."</p> <p>R1's Nurse's Notes, dated 10/6/14 at 7:15 p.m., states, "(R6) states that (R1) came into (R6's)</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 6</p> <p>room and climbed out the window. A facility wide check is initiated and ground check is done. R1 is not found at this time." At 8:45 p.m. the same day, R1's Nurse's notes state, "Security received call that (R1) has been found. Staff members sent to pick (R1) up." At 8:50 p.m. Nurse's notes state, "(R1) returns to facility at this time via car and a staff member." At 9:15 p.m. Nurse's notes state, "(R1) is transported to local hospital via ambulance." On 10/7/14 at 8:30 a.m., R1's Nurse's notes state, "(R1) returns from local hospital via facility staff. (R1) escorted to (R1's) room where (R1) directly went to bed...Continue on 10 minute checks..."</p> <p>R1's Emergency Department Discharge Safety Plan, dated 10/7/14, states, "It is recommended that the facility revise (R1's) sleeping arrangement so that (R1) is able to be observed at night to prevent (R1) from escaping out of the window, and keeping (R1) safe providing (R1) with one on one assistance."</p> <p>On 10/9/14 at 4:25 p.m., E16 (Registered Nurse) stated, "On 10/6/14, R6 notified me that a female resident climbed out of (R6's) window at the same time that a Certified Nursing Assistant said they couldn't find (R1). Immediately I started a search on the grounds, called (R1's) mother, and the police. Then we got the call from a person in the community saying that (R1) was at their house. Then, we sent staff to pick (R1) up. (R1) returned with no injuries. We kept (R1) in the main lobby area until she left to go to the hospital. My concern is that the more (R1) gets out the more it increases (R1's) risk for injury. (R1) needs a one to one to keep (R1) in the building. (R1) has the mind of a child."</p> <p>On 10/9/14 at 10:45 a.m., E6 (Certified Nursing</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 7</p> <p>Assistant) stated, "On 10/6/14, the last time I saw (R1) was in the dining room eating supper between 6-7 p.m.. A little bit after that I went looking for (R1) and didn't find (R1). I went into (R1's) room and the window was open. (R6) told me (R1) climbed out of (R6's) window. (R1's) shoes were underneath the window. (R1) must have taken them off before (R1) went out the window. I immediately told the nurse then we all started looking for (R1), while the nurse called the police...When (R1) got back to the facility we kept a close eye on (R1) and the nurse called the doctor. (R1) was sent to the hospital. (R1) had a history of attempting to leave the facility before this incident. (R1) likes to take walks with staff, but when (R1) gets outside (R1) attempts to run off. (R1) has attempted to climb out (R1's) window before, also."</p> <p>On 10/9/14 at 9:10 a.m., E9 (Registered Nurse) stated, "(R1) returned to the facility at 8:30 a.m. on 10/7/14 per the facility vehicle from the local hospital. (R1) had orders for one on one cares, but we can't provide one on one care. We are not a locked unit. We do not provide one on one care."</p> <p>On 10/9/14 at 11:45 a.m., Z2 (R1's Mother) stated, "(R1) climbed out of another resident's window. (R1) was found a couple of blocks from the facility. I had to tell the facility (R1) was missing. I spoke with E2 (Director of Nursing) and E2 said it was a staff error that (R1) got out. (R1) has not ran away for the last 17 years. (R1) hates it at the facility."</p> <p>On 10/9/14 at 11:45 a.m., Z1 (Citizen in community who lives approximately one mile from the facility) stated, "I found (R1) Monday night (10/6/14). My older daughter and her son pulled</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 8</p> <p>into my driveway and (R1) walked up to my daughter and asked my daughter to take (R1) to (another town approximately 80 miles from the facility.) (R1) was walking in socks with no shoes. (R1) pointed to my daughter's son and asked him to walk (R1) to church. I said I'm sorry I can't help you. (R1) was walking down the main avenue nearby and I told (R1) I would call someone. We fed (R1) dinner. We called (R1's) Grandmother in (the town 80 miles away) and (R1's) mother. (R1) was very confused. We spoke with the facility and they said we aren't missing anyone. Then (R1's) mother called the facility and told them yes you are missing someone. The facility came to get (R1). (R1) was at our house for over an hour to an hour and a half, (R1) first arrived about 7:00 p.m."</p> <p>On 10/9/14 at 11:10 a.m., R1 was in the conference room, confused, asking to see R1's mother. R1 exhibited a flat affect on R1's face with a blank stare. R1 repeatedly asked where R1's mother was. R1 was unable to answer questions regarding R1's attempts to leave the facility, disoriented, and kept talking about R1's mother.</p> <p>On 10/14/14 at 1:30 p.m., R6's room was empty. R6's window faces a neighboring apartment complex with a sidewalk beneath it.</p> <p>On 10/14/14 at 2:45 p.m., E13 (Maintenance) stated, "After (R1) left I heard the window screen in R1's room was missing, so I fixed it. Then (R1) was moved to another room. I put a new screen in room B11."</p> <p>On 10/9/14 at 9:35 a.m., E5 (Certified Nursing Assistant) stated, "(R1) has left several times. (R1) jumps out (R1's) window and gets out the</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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	<p>Continued From page 9</p> <p>front door when someone else goes out...(R1) is on ten minute checks and has been since (R1) has been here..."</p> <p>On 10/9/14 at 1:10 p.m., E4 (Licensed Practical Nurse) stated, "Certified Nursing Assistants (CNAs) are to watch (R1) every ten minutes. (R1) has not been a one on one currently or since (R1) has returned on 10/7/14. The CNAs check on (R1) in (R1's) room every ten minutes. (R1) is not always with the staff..."</p> <p>On 10/9/14 at 1:20 p.m., R1 was walking in R1's room with a flat affect and nonverbal. R1's room window opens to a fenced courtyard.</p> <p>On 10/9/14 at 1:25 p.m., E7 (Certified Nursing Assistant) stated, "I check on (R1) every ten minutes. We do not stay with (R1) at all times. (R1) is usually in (R1's) room or a sitting area.... (R1) doesn't follow us..."</p> <p>On 10/9/14 at 12:30 p.m., E2 (Director of Nursing) stated, "(R1) has not had a pass to leave...(R1) went out with a peer on 8/4/14 when the police returned (R1). If (R1) left with a peer I would hope she would have had a pass. (R1) came back to the facility 10 minutes after the male peer returned. (R1) was put on 10 minute checks after this, but (R1) was started on 10 minute checks from the time (R1's) been here...I'm not aware that (R1) attempted to climb out of the window prior to 10/6/14, just that (R1) tries to get out of the door. No one has said anything to me about (R1) attempting to get out of (R1's) window. (R1's) window screen was out the night we noticed (R1) was missing...When (R1) returned from the emergency room on 10/7/14, (R1) was put on one to one where (R1) follows staff around. We do not document (R1) being on one to one checks. (R1) is on written 10 minute</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007298	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SHARON HEALTH CARE PINES	STREET ADDRESS, CITY, STATE, ZIP CODE 3614 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 10 checks. (R1) is with staff at all times and if (R1) is not on one to ones, then (R1) is on 10 minute checks. Someone is constantly watching (R1) and knows where (R1) is at all times. If we didn't watch (R1) constantly, (R1) would be out. (R1) constantly tries to get out any chance with any open door. (R1's) room was changed when (R1) returned so if (R1) got out (R1) would go into fenced area, and so staff can see (R1) at all times...No new interventions were implemented on the care plan for the 8/4/14 and 10/6/14 incidents." On 10/14/14 at 4:40 p.m., E2 (Director of Nursing) stated, "I was unaware of (R1) leaving the building on 9/30/14...The nurse did not notify me and I did not receive an accident/incident report. The nurse knows better than that."	S9999		
-------	---	-------	--	--

SHARON HEALTHCARE PINES

Without prejudice, this Plan of Correction is being submitted in accordance with federal Medicaid requirements. Submission of this Plan of Correction is not an admission that a deficiency exists or that a deficiency was cited correctly. This facility reserves the right to disagree with, or contest, any violation which may be forthcoming.

This Plan of Correction is our allegation of compliance.

F 323

The facility immediately placed R1 on continuous 1:1 monitoring, from direct care staff.

Initial Staff inservice initiated on 10/9/14 to review elopement, resident safety, and the specifics of increased monitoring including 1:1 supervision duties.

Entire house scrutinized by IDT to identify residents at higher risk for elopement, 4 additional residents identified. High elopement individuals identified in this audit had care plans adjusted, with approaches added and initiated by direct care staff. One additional resident placed on 1:1 supervision. High risk individuals were reassessed for community access, BIMS, Wandering, and SLUMS. Pass status revisions were made as indicated.

Maintenance staff initiated whole house environmental rounds to ensure facility's windows and screens intact, and in working order.

Originally, the facility had window stops preventing egress from resident rooms as our population is generally young and agile. Local fire authorities made the maintenance department remove them. In a phone Conversation with Bill Myer with the IDPH-Life Safety Division on 10/10/14, he indicated that their Life Safety Codes adheres to the NFPA 2000 Federal code and would not prohibit limiting window egress in a long term care environment. Call to district Fire Marshall's

Accepted

office made. Fire Marshall Dan McGann indicated that they additionally concurred with the IDPH 2000 federal code where window stops were allowable to ensure resident safety. Final call made to the State Fire Marshall's Office, Mary Levault, Regional Administrator who reiterated that window stops were permissible. Rick Harper, Maintenance Director at Sharon Pines ordered whole house window stops 10/10/14. Installation of window stops was completed 10/13/14.

1:1 Direct Care Staff observation continued on R1 until her discharge date of 10/11/14. The additional resident identified as high risk for elopement was continued on 1:1 supervision until his medications were successfully altered per the facility psychiatrist and his behavior had abated. He then transitioned to 10 minute checks, then the hourly check list, with no subsequent issues. This resident remains on restricted pass status. Inservicing for the entire staff was completed by 10/16/14, to ensure whole house compliance. A Maintenance Audit to be conducted on a monthly and as needed basis by maintenance personnel to ensure existing window stops are intact and functioning properly (see enclosure). Administrator and Director of Maintenance to monitor for ongoing compliance.

Abatement accepted date: 10/9/14.

Final Completion date 10/16/14.

See Attached enclosures:

- #1. Time Frame/Responsible Staff Designation.
- #2. Whole House Window/Screen audit 10/9/14.
- #3. Whole House Window/Screen audit 10/10/14.
- #4. Window Stop Installation Confirmation.
- #5. All-staff Inservice.
- #6. Window Stop Audit Quality Assurance Tool.

Acceptable