

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E888	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/11/2025
NAME OF PROVIDER OR SUPPLIER Sharon Health Care Willows		STREET ADDRESS, CITY, STATE, ZIP CODE 3520 North Rochelle Peoria, IL 61604	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31285</p> <p>Based on record review, and interview, the facility failed to ensure a resident was free from abuse for one (R2) of three residents reviewed for abuse in a sample of four.</p> <p>Findings include:</p> <p>The facility's Incident Investigation Report, dated 3/30/25 at 12:08 PM by V1 Administrator, documents: On 3/30/25 at 12:08 PM in the North Dining Room, (R2) wheeled up to the table where (R1) was sitting. (R1) stated (R2) kept running into his wheelchair. (R1) then hit (R2) in the back of the head with an open hand.</p> <p>R1's Nursing Progress Notes, dated 3/30/25 at 12:08 PM by V3 RN/Registered Nurse, documented the incident as follows: Staff alerted this RN to the dining room due to an altercation with peer resident (R2). Per staff witness, peer resident (R2) was wheeling himself in the dining room when he went to (R1's) table. (R1) told peer (R2) that he did not want him sitting in his table then he hit peer (R2) resident on his head. Residents then separated. Per resident (R1), peer (R2) resident keeps on backing his wheelchair into his wheelchair. (R1) told peer (R2) resident to stop but peer (R2) resident continued doing so. (R1) then hit peer (R2) resident on the back of his head. (R1) educated on calling staff for assistance if there is any misunderstanding with peers and avoid physical contact with peers. (R1) verbalized understanding.</p> <p>On 4/10/25 at 2:05pm, V1 Administrator verified R1 hit R2 in the back of the head with an open hand on 3/30/25 while in the Dining Room.</p> <p>On 4/11/25 at 11:50am, V3 RN/Registered Nurse stated she was the Nurse on duty for R1 and R2 at 12:08pm on 3/30/25. V3 stated this is when R1 hit R2 in the back of the head with an open hand while in the Dining Room. V3 stated V3 reported the incident to V1/Administrator/Abuse Prevention Coordinator.</p> <p>On 4/11/25 at 1:50pm, V5 Security stated he was in the Dining Room and saw R1 hit R2 in the head with an open hand when R2 was attempting to sit at R1's table.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse Prevention Program Facility Policy, undated, documents the following: Abuse means any physical or mental injury or sexual abuse inflicted upon a resident other than by accidental means. Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.</p>		