

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 07/17/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy to ensure resident to resident physical abuse did not occur for one resident (R1) reviewed for abuse in a sample of five. Findings include: Facility's Initial and Final Reports to (State Department of Public Health) document: On 6/2/25 (R1) was noted on the patio when his wheelchair tipped back. Initial reports stated (R1) did a wheelie and fell. Further investigation, (R1) stated four residents (R2-R5) hit him multiple times and pulled his wheelchair back. R1 stated he did not fall out of his chair. R1 stated that R4 pulled his/R1's wheelchair backward. Residents (R2-R5) involved were questioned and admitted they hit him/R1. Police were called. R1's Minimum Data Set/MDS dated [DATE] documents R1 has a BIMS (Brief Interview of Mental Status) of 14 on a scale of 00 - 15. (MDS indicates that on a scale of 0 - 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.) (Documentation shows that R2, R3 and R4 have BIMS of 15; R5 has a BIMS of 13.) R1's current Care Plan documents: (R1) has a history of provoking peers. He requires assist of staff due to weakness/paralysis to left arm and leg related to history of stroke and traumatic brain injury. (R1) has history of behavior of purposely sliding himself down in his wheelchair even immediately after staff has repositioned him. (R1) has diagnosis of epilepsy with no recent episodes noted. (R1) is at risk for falls due to impaired balance and mobility. On 7/16/25 at 12:25pm, R1 stated that during the 6/2/25 altercation with R2-R5, They beat me up; one guy flipped my chair, tilted me back and I couldn't move. They just don't like me. On 7/17/25 at 9:15am, R1 stated that R4 Grabbed my wheelchair and flipped it over. On 7/17/25 at 9:35am, R2 stated regarding the 6/2/25 incident with R1, Everything happened so fast. Minding my own business; (R1) had called my mother a bitch and also called R5 a bitch; I laughed at (R1) about the whole thing and that's what he gets. On 7/16/25 at 12:50pm, R3 stated that on 6/2/25, that he was on the patio for smoking break. R3 stated that he had just gone to court in person today for the incident with R1; and got six months court supervision. R3 stated, I plead guilty to battery. R3 stated R3 was charged with mob action, aggravated battery. R3 stated that R1 got smart and cursed at R3. R3 stated, I have Post Traumatic Stress Disorder/PTSD and I popped (R1) in the mouth. He likes to be in everyone's way out on the patio. Asked him to move and he said to me Fxxx you fat ass, and I punched him in the mouth. There are four defendants including R2, R4 and R5, and we all got charged. On 7/16/25 at 12:50pm, R3 stated that during the incident, R1 was screaming and they/staff heard him. R1 got exactly what the hell he deserves; he bullies and curses everyone, even staff. On 7/16/25 at 1:00pm, R4 stated that he did not know who hit R1 first but did admit to hitting R1 as well. On 7/16/25 at 12:45pm, R5 stated, I hit him (R1) because he kept calling me a bitch, and my mother used to call me that and that triggered me. R5 stated that she did apologize to R1. On 7/17/25 at 12:45pm, V1 Administrator stated that she was surprised she did not hear about the 6/2/25 incident initially as a physical altercation. V1 stated V1 was surprised that R1 nor any of the other residents did not report the altercation. V1 stated, The residents do talk. I did not see R1 trying or attempting to do wheelies on the video (facility camera video of 6/2/25 incident); R1 was moved to the South Hall on 6/3/25 after review of the video; he did not go to the hospital; no injuries. On 7/17/25 at 10:17am, V4 Rehab Social Worker stated that the 6/2/25 altercation with R1 and R2-R5 was on a Monday around 11am; stated that she was outside the facility on her cigarette break and heard R1 yelling 'Staff'; stated that R1 yells staff all the time, like just to have TV on, to get him a soda. V4 stated that R1 kept yelling and she wondered why. V4 stated that she V4 went inside the building and went to the patio; did not see him at first, that R1 was flipped backwards in his wheelchair. At this same time, V4 stated that when she went to tend to R1 for his yelling, that R2-R5 were laughing--saying that R1 was trying to do a wheelie. V4 stated that she V4 asked the residents why not get help and they said, Because it's (R1). On 7/17/25 at 10:17am, V4 stated that on 6/3/24 when they ran the camera video back, saw that R2 hit R1 first in the face; R5 hit him on his leg and arm, then R3 hit R1 in his face on the right side a couple of times; stated that R4 then hit R1 in the face, got up from R4's own wheelchair, laid the back of R1's wheelchair back and flipped R1 backwards. V4 stated that after the video was viewed, that R2-R5 admitted to hitting R1. V4 stated, R5 was the first one who said she was sorry; and she apologized to R1 before he was moved to the South Side from the North side. R3 was making threats and said he should have done more to R1. The Facility's Abuse Prevention Program Policy Dated 6/3/24, documents: This facility affirms the right of our residents to be from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility is committed to protecting our</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to monitor, supervise, and follow its policy to ensure safe smoking environment for two residents (R1, R4) of five residents reviewed for smoking in a sample of five. Findings include: Documentation and interviews indicated that R1 and R4 were smokers. The facility's Incident Investigation Report Dated 6/2/25 documents both R1 and R4 were on the facility's patio for a smoke break when an altercation occurred involving R1 and R4. 1. R1's current Care Plan documents: (R1) is a level III supervised smoker. Interventions: Staff will remind (R1) about smoking policy and procedures as needed. Staff will supervise and assist (R1) with smoking safely. 2. R4's current Care Plan documents: (R4) is a smoker and requires supervision while smoking to maintain safety. Interventions: Staff will remind resident about smoking policy and procedures as needed. Staff will supervise and assist resident with smoking safely. On 7/16/25 at 12:50pm, R3 stated that there were no staff on the smoking patio prior to (6/2/25 altercation involving R1). R3 stated, After the incident, (R1) was screaming and they heard him; (V4 Rehab Social Worker) heard (R1) and came to the patio. On 7/17/25 at 9:35am, R2 stated that there were no staff on the patio on 6/2/25. R2 stated, They (Staff) came out there right after the mess (altercation involving R1). On 7/17/25 at 9:18am, R5 stated that no staff were out on the patio on 6/2/25 and staff had not been out there for their smoke breaks even prior to the 6/2/25 incident. R5 stated, Now they (Staff) have to be there since the incident. On 7/17/25 at 9:45am, V3 Activity Director stated that Staff were probably not out there on the patio to supervise on the 6/2/25 incident date. V3 stated that independent smokers could have been out on the patio without supervision. V3 stated, (R1) should not have been out there with staff monitoring; he is not independent; (R4) was supervised like (R1). On 7/16/25 at 2:30pm, V1 Administrator stated: There were no staff on the patio to supervise; a staff should have been out there supervising. The Activity Aide (V5) should have been on the patio supervising. He was supposed to be but stepped away to do a one on one when another staff had to step away. Facility's Smoking Safety Policy and Procedure, updated 6/5/25, documents: Supervised Smoking Program: Patients in the supervised smoking program need assistance and monitoring to maintain safety while smoking. The facility's Smoke Pass Times documents: Scheduled resident n times include 7am by designated staff: Security; 9am, 11am, 1pm, 3pm, and 5pm by designated staff: Activities.</p>		