Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

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	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Health Care Willows	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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131 Based on observation, interview, and record review, the facility failed to update a care plan to include targeted behaviors and non-pharmacological interventions for two (R7 & R51) of 23 residents reviewed for care plan revision in a sample of 30. Findings include: Facility policy Care Plan Policy, updated 6/5/24, documents Patients receive care and treatment based on an assessment of their needs. The data is used to determine and prioritize the patient's plan of care. 1. R7's medical record documented R7 was alert and oriented, admitted to the facility on [DATE], and had Schizophrenia. R7's current physician orders for October 2024 documents R7 takes the following: Lorazepam 1 MG (milligram) by mouth two times a day for anxiety started 2/17/24; Zoloft 200 mg by mouth at bedtime started 2/27/24; Risperidone (antipsychotic) 5 mg by mouth two times a day started 2/28/24; Olanzapine (antipsychotic) 20 mg by mouth at bedtime started 5/28/24; and Trazodone (antidepressant) 50 mg by mouth at bedtime started 2/16/24. On 10/15/24 and 10/16/24 between the hours of 9 AM and 2 PM multiple observations were made of R7 in her room and in the dining room with no behaviors noted. On 10/17/24 at 11:10 AM, R7 was coming out of her room, no behavior noted, and stated she has hallucinations a lot that tell her to harm herself, and her hallucinations are from the past and present. R7's current care plan has no behaviors identified or documented with interventions, and no non-pharmacological interventions listed. On 10/17/24 at 11:20 AM, V3 RN/Registered Nurse Care Plan Coordinator verified R7's care plan does not have targeted behaviors with interventions, or non-pharmacological interventions listed and should. 2. R51's medical record documents R51 had Schizoaffective Disorder and Altered Mental Status, and did not take any Psychological medications. (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 9:41 AM, R51 was yelling out in her room, surveyor went in the room to introduce herself, resident told surveyor to Get the hell out of my room, I don't want to talk to you and then slammed her door shut and continued yelling in her room. On 10/17/24 between 11:44 AM and 11:50 AM, R51 was yelling out in her room while lying on her bed. No staff members were present or went into R51's room. On 10/17/24 at 11:50 AM, V12 CNA/Certified Nurse Aid stated She (R51) always yells out, sometimes it is in the dining room and we have to take her to her room, that is her behavior. R51's current care plan had no behaviors identified or documented with interventions, and no non-pharmacological interventions listed. On 10/17/24 at 11:20 AM, V3 RN/Registered Nurse Care Plan Coordinator verified R51's care plan did not have targeted behaviors with interventions, or non-pharmacological interventions listed and should.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 38396 Based on Observation, Interview and Record Review the facility failed to ensure a range of motion program was in place for residents with functional limitations in range of motion for three of five residents (R8, R47, R90) reviewed for range of motion in the sample of 30. Findings include: The facility's Restorative Program Policy, dated 6/6/24, documents It is the policy of this facility that a resident is given the appropriate treatment and services to maintain or improve his or her abilities, as indicated by the individual's comprehensive assessment, to achieve and maintain the highest practicable outcome. Our goal is to promote each resident's ability to maintain or regain the highest degree of independence as safely possible, and to achieve and preserve their highest level of mental, physical and psychosocial functioning. Restorative nursing is available seven days a week and is provided for the residents with assessed needs according to program criteria. Purpose: The restorative nursing program is designed to Preserve function, Promote optimal improvement, Increase independence, self esteem and dignity, Promote safety, Minimize deterioration within the limits of normal aging and/or recognized disease process. This same policy documents An individualized program will be developed based on the resident's restorative needs, and include the restorative program on the care plan. 1. On 10/15/24 at 10:10 AM, R8 was observed in bed sleeping in a contracted like fetal position. R8's Minimum Data Set assessment, dated 8/28/24, documents R8 has limits in range of motion with Impairment to bilateral (both sides) lower extremities. R8's current Care Plan does not document a plan of care for R8's range of motion limitations or interventions/programming to prevent further decline. 2. On 10/15/24 at 10:05 AM, R47 was in her room in a bariatric bed. R47 stated she relies on staff to get in and out of bed. R47 denied doing exercises or having staff complete range of motion in her hips, knees or ankles. R47's Minimum Data Set assessment, dated 8/19/24, documents R47 has limits in range of motion with Impairment to bilateral lower extremities. R47's current Care Plan does not document a plan of care for R47's range of motion limitations or interventions/programming to prevent further decline. 3. On 10/15/24 at 11:50 AM and 10/16/24 at 10:45 AM, R90 was observed in common resident areas in her wheelchair. R90's arms were frequently in the bent (contracted at the elbow) position and movements of R90's arms and legs appeared spastic at times. R90's Minimum Data Set assessment, dated 9/16/24, documents R90 has limits in range of motion with Impairment to bilateral upper and lower extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R90's current Care Plan, dated 6/13/24 documents R90 has diagnoses of Huntington's Disease and Primary Osteoarthritis. This care plan does not document a plan of care for R90's range of motion limitations or interventions/programming to prevent further decline. On 10/17/24 at 10:30 AM, V19 (Rehabilitation Aide/Certified Nursing Assistant (CNA)) confirmed she is the one who over sees the restorative program for CNAs and Range of Motion therapies. V19 stated she receives the list of residents who are in need of restorative from V20 (Licensed Practical Nurse/Assistant Director of Nursing) and R8, R47 and R90 are not on the list. V19 stated Those three residents are not receiving any active or passive range of motion that I am aware. On 10/17/24 at 10:30 AM, V19 (Rehabilitation Aide/Certified Nursing Assistant (CNA)) confirmed she is the one who over sees the restorative program for CNAs and Range of Motion therapies. V19 stated she receives the list of residents who are in need of restorative from V20 (Licensed Practical Nurse/Assistant Director of Nursing) and R8, R47 and R90 are not on the list. V19 stated Those three residents are not receiving any active or passive range of motion that I am aware.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34131 Based on observation, interview, and record review, the facility failed to implement non-pharmacological interventions, and failed to identify, document or track behaviors for one (R7) of six residents reviewed for psychotropic medications in a sample of 30. Findings include: Facility policy Psychotropic Medication, undated, documents Each psychotropic medication is tracked for behaviors, mood/depressions. Psychotropic medications are used when non-pharmacological approaches have previously failed. Identify target symptoms/behaviors. R7's medical record documents R7 was alert and oriented, admitted to the facility on [DATE], and has Schizophrenia. R7's current physician orders for October 2024 documents R7 takes the following: Lorazepam 1 MG (milligram) by mouth two times a day for anxiety started 2/17/24; Zoloft 200 mg by mouth at bedtime started 2/27/24; Risperidone (antipsychotic) 5 mg by mouth two times a day started 2/28/24; Olanzapine (antipsychotic) 20 mg by mouth at bedtime started 5/28/24; and Trazodone (antidepressant) 50 mg by mouth at bedtime started 2/16/24. On 10/15/24 and 10/16/24 between the hours of 9 AM and 2 PM multiple observations were made of R7 in her room and in the dining room with no behaviors noted. On 10/17/24 at 11:10 AM, R7 was coming out of her room, no behavior noted, and stated she has hallucinations a lot that tell her to harm herself, and her hallucinations are from the past and present. R7's medical record has no behaviors identified or documented, and no non-pharmacological interventions implemented for the use of psychotropic medications. On 10/17/24 at 11:20 AM, V3 RN/Registered Nurse verified R7's medical record does not have targeted behaviors, or non-pharmacological interventions and should. On 10/17/24 at 11:30 AM, V12 CNA/Certified Nurse Aid stated We chart behaviors in our (online) charting system, it walks us through the system.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38396 Based on observation, interview and record review, the facility failed to ensure use of a safe sanitation solution, record sanitation solution checks, ensure kitchen trash bins were kept away from food preparation areas and covered, maintain clean floors in the kitchen, and ensure the ice machine scoop was handled and stored appropriately to avoid cross contamination in the facility's kitchen. This failure has the potential to affect all 115 residents living in the facility. Findings include: The facility's Sanitation Checks, dated October 2024, documents Take the designated bleach bucket and fill with luke warm water (70 degrees). Using dispenser add bleach water and mix. Test solution if it is not 100 ppm (parts per million), add more bleach, mix and test. Record results and initial. Procedures are to be done at least prior to the start of each meal. Buckets are changed more often if needed. On 10/15/24 at 10:00 AM, V9 (Dietary Manager) confirmed the facility's sanitizing bucket is used to wipe food preparation surfaces in the kitchen and the solution should be at least 100 ppm but not higher than 200 ppm. V9 then took a solution test strip and tested the sanitizing bucket solution and result was 10 ppm. V9 stated It is too weak for solution at 10 ppm. It should be at 100 ppm and will need remade. On 10/16/24 at 11:00 AM, V9 checked the sanitation solution, and it measured above 200 ppm. V9 stated The solution is too high and needs remade. At this time V9 provided the October 2024 Solution Check list. This checklist did not document any sanitizing solution checks were completed on 10/16/24. The facility's Waste Disposal policy, dated 2017, documents Garbage will be disposed of and as needed throughout the day and at the end of each day. Procedure: Prior to disposal, all waste shall be kept in leak-proof, non-absorbent, fireproof containers that are kept covered when not in use. On 10/15/24 at 9:30 AM, three large barrel trash cans were present in the facility's kitchen. All of the cans were not covered/open to air and placed in random walkways of the kitchen. On 10/15/24 at 11:45 AM, a open large barrel trash can that contained food waste and trash was sitting in the facility's kitchen within two feet of the facility's steam table, which contained prepared food for the noon meal. Another open large barrel trash can containing food and product packaging waste, was directly next to the kitchen's grill where food was being prepared. On 10/16/24 at 11:00 AM, three open large trash barrel trash cans were observed in the kitchen. One was sitting by the reach in cooler and two were located against the wall between the steam table/serving window and the dishwashing machine. All three barrels contained trash, liquid splatter and food contents. At this time V9 stated We should have some lids for those. V15 (Dietary Aide) stated We don't have lids for those. In the five years I have worked here, I have never seen lids on them (kitchen trash cans). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's General Sanitation of Kitchen policy, dated 2017, documents Food and Nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. On 10/15/24 at 9:30 AM, a tour of the facility's kitchen was conducted. During this tour the kitchen floor was observed to be dirty with dirty grout and particle debris on the floor in several areas including corners and along the edges of the walls. The floor was also noted to be sticky when walking. During the tour V9 (Dietary Manager) confirmed the floors sticky feeling and debris throughout and stated They (the facility) are looking to replace the floor in here, but it should be getting cleaned multiple times throughout the day. On 10/16/24 at 11:00 AM, the facility's kitchen floor was observed to have debris and particles scattered in several areas of the kitchen. The floor in the juice machine area contained a yellow shiny slime-like substance under the machine, around the cart and by the wall. This same area of floor also contained a brown, thick, gritty substance around the juice cart and against the wall. Two drink sweetener paper packets and approximately one fourth of a full orange was on the floor near the wall. At this time, V9 confirmed the condition of the floor near the juice cart and made kitchen staff aware, stating There is an orange against the wall over here! The facility's Ice policy, dated 2017, documents Ice will be provided and handled in a manner to keep it free from contamination. Ice will not be handled with bare hands, but rather with a sanitized scoop and container for transport and distribution. On 10/16/24 at 11:00 AM, V9 (Dietary Manger) stated the kitchen does not have an ice machine so any ice for the food tables and resident drinks would be obtained from the resident F-hall ice machine and transported to the kitchen via a cooler and cart. At this time V9 walked to the North side nurses' station where halls F, G and H are located. V9 pointed to a cart at the nurses' station and stated it contains the ice scoop and cooler used for kitchen purposes. The second level of this cart contained an ice scoop open to air and resting on a surface with unknown particles, brown specs and debris. V9 grabbed a brown tray from the dining area and placed the scoop on the tray then stated, I will get a bag to cover that (ice scoop). V9 confirmed this ice scoop is the only one used in the ice machine, ice cooler and for kitchen ice purposes. On 10/16/24 at 11:15, R6 walked up to the ice cooler cart and grabbed the ice scoop with bare hands, filled a personal cup and then walked away leaving the scoop on the cart. V22 (Certified Nursing Assistant) was the only staff in the area at this time and confirmed R6 is a resident who resides in the H-hall.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38396 Based on observation, interview and record review, the facility failed to ensure a resident's leg wounds were protected from cross contamination during scheduled dressing changes for one of four residents (R47) reviewed for skin conditions in the sample of 30. Findings include: The facility's Treatments policy (undated), documents The treatment will be carried out in accordance with physician orders, pharmacy recommendations and CDC (Centers for Disease Control) guidelines, using universal precautions. The facility's Skin Treatment Protocol, dated 6/5/24, documents The facility strives to ensure that each resident receives care and services necessary to attain and maintain the highest practicable overall well-being, in accordance with the comprehensive assessment and plan of care. This policy also documents when treating a wound: Sterile technique is not necessary, unless ordered by a physician. Clean technique is used for all other dressings and universal precautions are adhered to. If clean, un-sterile dressings are used, then measures must be taken to prevent contamination of unused dressings. R47's current care plan, dated 9/7/23, documents R47 has actual impairment to skin integrity related to occasional urinary incontinence and limited mobility. Right lower lateral leg (wound measurement)7 cm (centimeters) x 2 cm x 0.1 cm. Right posterior lateral thigh (wound measurement) 1.5 cm x 10.5 cm x 0.2 cm. Right lateral calf (wound measurement) 0.9 cm x 0.5 cm x 0.1 cm. This same care plan contains a historical active plan of care that documents (R47) is being treated with antibiotic therapy for a wound on her right thigh. Antibiotic order date 8/22/24-9/5/24. Maintain universal precautions when providing resident care. On 10/17/24 at 10:00 AM, V21 (Registered Nurse (RN)) and V3 (RN/Infection Control Preventionist) went into R47's room to complete wound care to R47's right leg wounds. R47 rolled in bed to her left side for treatments to begin. A moderate amount of brown smeared stool was noted in the center of R47's buttocks when she rolled over. V21 placed a disposable drape on R47's bed under her buttock and hip. V21 then took bandage scissors and cut R47's hip/thigh dressing and without sanitizing, then used the same scissors to cut the lower leg gauze wrap off. A strong odor was noted from lower leg when dressing was removed. After cleansing R47's hip wound, V21 used same (un-sanitized) scissors to cut three pieces of Puracol (collagen treatment) and applied them to R47's hip/thigh wound. V21 used the same (un-sanitized) scissors to cut strips of calcium alginate and then applied them to the hip/thigh wound. While V21 waited for V3 to open a bandage, one square of calcium alginate fell on to the drape (where R47's soiled buttocks was laying) three times. Each time V21 picked up the calcium alginate and reapplied it to the wound before then covering the entire wound with a bandage. V21 proceeded to use the same scissors (still un-sanitized) to cut strips of Puracol for R47's calf wound and applied two cut pieces to the lateral calf wound. After the wound care was completed V21 stated to R47 We are done. I will send (Certified Nursing Assistants) in to get you cleaned up (from stool). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 10:12 AM V21 stated the scissors used during R47's wound care are V21's and she did not think about sanitizing them between use when completing R47's wound cares. V21 confirmed that a piece of calcium alginate fell on top of R47's disposable drape three times during her treatment and R47's feces soiled bottom was laying on this drape. V21 stated I think R47 was having a bowel movement during her cares. At this time V21 confirmed the stool should've been cleansed to keep a clean field before performing wound care to avoid wound contamination.