STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007298	A. BUILDING: _____ B. WING _____	C 03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE PINES	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
S 000	Initial Comments Complaint Investigation 2021589/IL120595	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

care needs of the resident.

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:

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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to provide supervision to prevent a resident to resident altercation for two of three residents (R1, R2) reviewed for supervision in the sample of three. This failure resulted in R2 physically assaulting R1 and R1 being hospitalized for more than 8 days with a diagnosis of a new Intracranial Hemorrhage.

Findings include:

A facility Smoking Safety Policy and Procedure dated 6/3/19 documents: "Supervision, in addition to periodic observation, regular checks are made by staff of the patio smoking area at the time of the scheduled passes."

A Facility Smoking Report (undated) documents,

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S9999	Continued From page 2	S9999		

that both R1 and R2 are Managed (Supervised) smokers and can only go out to smoke with supervision.

An Incident/Accident report dated 2/24/2020 at 7:00 p.m. documents R1 was located on the unsupervised smoking patio and that R6 (witness) reported that R2 punched R1 and pulled her out of her wheelchair onto the ground. R1 was sent to the local hospital and R2 was arrested and taken to jail.

On 3/2/2020 at 11:56 a.m. V3 (Registered Nurse) stated that on 2/24/2020 in the evening, she was doing a medication pass for approximately 50 residents when a certified nursing aide came up to her and said there is a fight on the unsupervised smoking patio. V3 stated "One of the residents was yelling fight, fight and (R1) was on the ground in front of her wheelchair. I took R1's vitals and kept her on 15 minute neurological checks and within an hour or so she was not herself and her blood pressure was dropping and getting low, her respirations were more shallow and her neurological assessment (Glasgow coma scale) was a 7. (R1) became more lethargic so we called 911 and she was transferred out to a local emergency room. (R1) did not have her helmet on when I assessed her. The unsupervised smoking patio continues to be a problem, because I cannot keep my eye on all these residents and pass medications at the same time. (R1) should never be allowed to go out that door to the unsupervised patio so easily, the door is unlocked and she is able to push it out and open and then she is out there and you can't see her if you don't physically go out on the patio. I have mentioned that this is a problem and some of (R1's) altercations happen on the unsupervised smoking patio."

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R1's facility Smoking Assessment dated 11/15/2019 documents that R1 requires managed/supervised smoking materials, (R1) is on a managed smoking program.

R2's facility Smoking Assessment dated 2/11/2020 documents that R2 requires managed/supervised smoking materials.

R1's current computerized medical record documents R1 remains hospitalized at a local hospital since the resident to resident physical assault occurred on 2/24/2020.

R1's local hospital admission record dated 2/24/2020 documents that upon arrival to the emergency room, R1 would not open her eyes to command, did not have a gag reflex, was not making any understandable words or noises, had bruising to her face, had a posttraumatic right frontal scalp hematoma and a critical result of new intracranial hemorrhage identified. This same hospital record documents R1 was hypotensive on arrival with shallow respirations, R1 was intubated and transferred to the intensive care unit. R1's CT (Computed Tomography) of the brain dated 2/25/2020 indicates "Critical Result of New Intracranial Hemorrhage Identified."

On 3/2/2020 at 10:55 a.m. V1 (Administrator) stated: "(R1) is always getting out onto the unsupervised smoking patio, where she isn't supposed to be, and was either soliciting cigarettes for money or trying to bum a cigarette and that is why the altercation happened."

On 3/3/2020 at 9:55 a.m. R6 stated that "(R1) keeps coming out on the patio where she is not

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supposed to be and (R1) called the new girl (R2) some bad name and cussed her out and then (R1) threw her helmet at (R2) and then (R2) took the helmet and kept hitting (R1) in the head until I yelled stop."

On 3/2/2020 at 12:45 p.m. V2 (Director of Nursing) stated that there are residents who are allowed to go out and smoke without supervision and they use the unsupervised (independent) smoking patio and can go in and out when they want because that door is unlocked at all times. V2 further stated that there are residents who require supervision and are only allowed to be on the Supervised (Managed) Smoking Patio during scheduled smoke break times. V2 stated: "(R1) was not supposed to be out on the Independent Unsupervised Patio because she requires supervision when she goes out to smoke. (R1) is constantly getting out onto the unsupervised patio begging or bartering for cigarettes. The door to the unsupervised patio is located directly beside the nursing station in the main area, but that doesn't mean someone is always watching that door to see who goes in and out. It's impossible to supervise her at all times."

On 3/4/2020 at 11:10 a.m. V5 (Case Manager) stated "(R1) is not supposed to be out (on the unsupervised patio) and goes anyway and is able to get out there before staff see her. (R1) has been known to throw her helmet and hit people and she should have better supervision. Even after redirected, (R1) will get right back out there on the unsupervised patio."

(A)