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 06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE PINES	3614 NORTH ROCHELLE PEORIA, IL 61604

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S 000	Initial Comments FRI of 6-5-19/IL113048	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 are not met as evidenced by:

Based on observation, interview and record review, the facility failed to prevent abuse and monitor two high-risk residents with a history of physical altercations resulting in a resident to resident physical altercation for two of three residents (R1 and R2) reviewed for supervision in the sample of three. This failure resulted in R1 obtaining a facial fracture and requiring emergency medical attention.

Findings include:

The facility's undated Resident Pass policy documents "Restricted = Resident is deemed high risk for safety concerns and not to be out of the building independently."

The facility's monthly resident council minutes for the months of March, April and May 2019, all document "Residents are requesting more security and would like security to react faster to altercations."

R1's current care plan, dated 6/10/19, documents R1 has diagnoses of Extrapyramidal and Movement disorder, Intracranial injury without loss of consciousness, and Schizoaffective disorder. This same care plan documents "(R1) has the potential to be verbally and physically aggressive related to poor impulse control. (R1) is noncompliant of care often resulting in (R1's) safety being compromised. (R1's) cognitive impairments not accepting/unaware of limitations

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of diagnosis play a role in (R1's) behavior mood and emotion management." R1's care plan also documents "(R1) has impaired cognitive function or impaired thought processes related to difficulty in making decisions, head injury, impaired decision making, delusional thought process mood and emotion management as well as behaviors."

On 6/18/19 from 9:00 AM- 3:00 PM, R1 was observed multiple times self propelling in her wheelchair throughout the facility.

R1's nursing progress note, dated 6/5/19 at 11:43 PM, documents "At 8:30 PM (R1) went out to the A/B patio where she was not authorized to be at that time and was involved in an altercation with a peer (R2). Peer witnesses state that (R1) threw a soda can at a peer (R2) and then tried to grab his eye. Peer witnesses state that the peer (R2) then struck (R1) in the nose with a closed fist causing it to bleed. Pressure was applied and nose was cleansed with a cloth. Swelling noted in the nose and left fourth and fifth fingers. (R1) remained alert and oriented after the incident. Physician, family and administrator were notified. Orders received to send (R1) to the emergency room."

R1's nursing progress note, dated 6/6/19 at 4:15 AM, documents "(R1) returned to the facility via advanced medical transport wheelchair from being treated at (local hospital) emergency room. After visit summary indicates fracture of (R1's) nose."

R2's current care plan, dated 3/21/19, documents R2 has diagnoses of Intracranial injury without loss of consciousness, Extrapyramidal and Movement disorder, Psychosis, Borderline personality disorder, Major depressive disorder

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and Anxiety. This same care plan documents "(R2) has a background of violence, order of protection 2009, 1995, 1994, criminal damage to property 2009, aggravated stalking 1996, possession of controlled substance 1994, domestic battery 1988, (R2) has a diagnosis of Traumatic Brain Injury (TBI) risk assessment completed, (R2) was assessed at a moderate risk and placed on hourly checklist." R2's care plan also documents "(R2) has a behavior problem related to not accepting/unaware of limitations of diagnosis, poor impulse control, poor insight and decision making, poor coping skills and poor emotion management. (R2) displays behaviors' of verbal and physical aggression, intrusive, swears, threatens, inappropriate comments and demanding with staff, provokes peers and property damage, noncompliant with facility policies and activities of daily living."

On 6/17/19 at 11:05 AM, R2 was in his room in bed. R2 stated that on 6/5/19 he was involved in an incident with R1. R2 stated "I don't like it when (R1) is around; she is always picking on me."

R2's.nursing progress note, dated 6/5/19 at 9:18 PM, documents "At approximately 8:30 PM this resident was on outside back patio (designated smoking area) when a peer (R1) threw a can of soda at him and attempted to grab at (R2's) face. (R2) responded by striking peer (R1) in the nose with a closed fist causing peers nose to bleed. Peer (R1) was sent to the emergency room for evaluation and treatment via advanced medical transport. (R2) did not sustain any obvious injuries; however, stated that his lower back hurt as a result of this altercation."

On 6/17/19 at 10:55 AM, V6 (Licensed Practical Nurse) stated "The supervised patio is labeled the

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A/B patio and there are set times for residents to go there for smoking. On the supervised patio, staff are to be out there with the residents."

On 6/18/19 at 10:10 AM, V9 (Certified Nursing Assistant) stated "(R1) is allowed to be out on the patio when she's not smoking. But anyone on the supervised side (A/B patio) should have some supervision to be out there. If they're on that side, there should be staff there to supervise them. (R1) has a lot of behaviors. She's always touching and irritating people and then people get mad and want to kick her butt. (R1) provokes people and she knows who she can irritate. (R1's) pretty equal at who she picks on. There's several that she gets into a lot of arguments with."

On 6/17/19 at 11:15 AM, V4 (Registered Nurse) stated "I wasn't on the patio the night of 6/5/19. I was down the hall doing a medication pass and (V5, Registered Nurse) came and told me about what happened. I went and talked with (R2). He was not injured but then later said he had a little back pain. (R2) said (R1) threw a full soda can at him and he said he pushed her, but (V5) said (R2) hit her with a closed fist. (R1) is not supposed to go outside unless she is supervised. (R1) tends to get hostile and irritated with pretty much everyone, but particularly she doesn't like (R2)."

On 6/18/19 at 12:15 PM, V7 (Certified Nursing Assistant) stated "I wasn't out on the patio at all that evening. I didn't see the incident between (R1 and R2) happen. All I remember is (R2) hit (R1) in the face and she was bleeding. We take turns watching the front area and the door. I remember there was blood all over (R1's) face. (R1) and (R2) are always sneaking around, maybe they snuck out to the patio. I don't think

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any staff were on the patio with them. They (R1 and R2) are not supposed to be out on the patio by themselves. There's not enough staff and too many people. The residents have a lot of fights, all the time."

On 6/18/19 at 2:30 PM, V2 (Director of Nursing) stated "(R1) and (R2) do not have any passes; they are Restricted. So they cannot leave the grounds or go into un-gated areas. Both of them are not appropriate to be in the community alone. They (R1 and R2) are both prone to getting into altercations. We always try to keep them apart from each other. (R1) kind of aggravates more residents than just (R2). Staff are supposed to re-direct (R1). Both (R1 and R2) should be supervised when in common areas or groups especially."

On 6/17/19 at 11:30 AM, V1 (Administrator) stated "I don't have any staff witnesses to the incident between (R1) and (R2). There were no staff on the patio at that time and none of the other residents will talk to me about it, or offer any information. I'm going to guess they were out there on a unauthorized smoke time and shouldn't have been out there. No actual staff were physically on the patio during this particular incident."

(B)