Illinois Department of Public Health

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 08/26/2021

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 Facility Reported Incident IL137344 from 8/16/21	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)3) 300.1210d)6) 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure a resident was not injured by another resident with known verbal and physical aggression for one(R1) of three residents reviewed for resident injuries in a sample of three. This failure resulted in R1 receiving a laceration to R1's head and fractures to R1's humerus and left maxillary.

Findings include:

The facility's Final Abuse Investigation Report dated 8/16/21 documents, "During the process of investigation, medical record review and interview of witnesses, the following facts were determined: Camera was reviewed. (R1) was in a manual wheelchair wheeling himself backwards and bumped into (R2) and (R2) turned around with force and flipped (R1) out of his wheelchair. (R1) went out of his wheelchair and landed on his face. (R2) had his fists balled up after this incident and sat in the dining area and watched staff assist (R1). (R2) seemed upset and continued to have his fists balled up."

On 8/24/21 at 12:30 PM video camera footage of the 8/16/21 incident involving R1 and R2 was reviewed with V2/Director of Nurses/DON. Video footage shows R1 hanging up the phone at the main nurse's station in the main dining room. R1 rolls himself backward around the desk and bumped into R2. R2 instantly grabs R1's wheelchair handles and shoves the wheelchair

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S9999	Continued From page 2 forward resulting in R1 flying forward out of the chair and landing on his face on the floor. R1's face was noted to be bleeding and staff were assisting R1 to roll over. R2 looked at R1 approximately two seconds then walked and sat in a chair in the main dining room. Staff are noted removing R2 from the dining room to the front office with security. R1's Progress Note dated 8/16/21 11:07 PM documents, "(R1) was transported to the emergency room related to left shoulder pain and laceration to left eye. (R1) was involved in an incident with another peer(R2). Awaiting updated status on (R1) at this time." R1's Progress Notes dated 8/17/21 at 5:33 AM documents, "(R1) came back from the hospital at 5 AM related to physical altercation with male peer(R2) on 8/16/21. Laceration of head, closed fracture of supracondylar humerus and left maxillary fracture." R1's After Visit Summary from a local hospital dated 8/17/21 documents, "Reason for Visit: Fall; Assault Victim. Diagnoses: Closed fracture of supracondylar humerus, left maxillary fracture, laceration of head, fall, head injury. Schedule an appointment with local Orthopedic Surgeon as soon as possible (8/18/21) for visit." On 8/26/21 at 12:18 PM V5/Certified Nurse's Assistant/CNA stated, R1 bumped into R2 and R2 lifted R1's wheelchair and shoved it forward, throwing R1 onto the floor. V5 also stated R2 stood there for a few seconds afterwards with clinched fists staring at R1 and then sat in a chair in the dining room with clinched fists for several minutes.	S9999		

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S9999	Continued From page 3 On 8/24/21 at 12:30 PM V2/DON confirmed R1 bumped into R2 with his wheelchair and R2 flung R1 from his wheelchair and R1 landed on the floor and had a fractured elbow and cheekbone. At this time V2 confirmed R2 is care planned for verbal and physical aggression and poor impulse control. V2 confirmed the facility has one security guard per shift. Resident Council minutes dated 4/30/21 and 7/28/21 documents, "Security: Residents would like to see more staff in general, residents are requesting security on the floor. Relayed to supervisor." R2's Current Care Plan documents, "(R2) is verbally aggressive related to poor impulse control, may be physically aggressive at times as well." R2's Progress Note dated 8/18/21 at 3:45 PM and signed by V6/Social Service Director documents, "1:1 with (R2). (R2) and this writer discussed a recent physical altercation from 8/16/21. (R2) feels that he was not in the wrong and that peer(R1) ran over his feet. (R2) stated "peer(R1) got what he deserved". This writer discussed with (R2) appropriate ways he could have handled the situation." (A)	S9999		