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 10/06/2022

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 of 9/30/22/IL151883	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d) 300.3210t) 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 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: Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced: Based on observation, interview and record review the facility failed to prevent an occurrence of resident to resident physical abuse from a resident with a known history of physical behaviors directed towards others for two of three residents (R1 and R2) reviewed for abuse in the sample of four. This failure resulted in R2 punching R1 in the left side of the face with a closed fist and calling R1 a "son of a b****." Findings include: The facility's "Abuse Prevention Program Facility Procedures, revised 9/15/22, states, "The facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment." R2's Nursing Note on 9/30/22 at 9:57 PM documents R2 was displaying increased episodes of psychosis with aggression and that R2 was in a physical altercation.	S9999		

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S9999	Continued From page 2 The facility's initial report to the local state agency, undated but with a fax submission date of 9/30/22, states, "At 9:00 PM, in the main dining room another resident (R2) hit (R1) with a closed fist in the face. The other resident (R2) has been displaying increased episodes of psychosis. (R2) involved in a physical altercation while on one-on-one monitoring. Unable to redirect. Police notified. (R2) transferred to (the local area hospital) for psych eval (psychiatric evaluation) per police/EMS (Emergency Medical Services). Family notified of behavior." R2's "Incident/Accident Report" dated 9/30/22, states, "(R2) has been displaying increased episodes of psychosis. (R2) involved in a physical altercation while on one-on-one monitoring." R1's "Incident/Accident Report" dated 9/30/22, states, "(R1) was involved in physical altercation with another male peer (R1)." V5's (Registered Nurse/RN) written statement states the following regarding the events on 9/30/22: "They (R1 and R2) were out in the main dining room, and it looked like (R2) hit (R1) out of the blue. Staff was around and immediately separated them. It was over right away. No idea what triggered the episode. Police came and just had (R2) sent to (name of local area hospital)." V4's (RN) written statement states the following regarding the events on 9/30/22: (R2) was in the main dining room. (R1) was wheeling toward his hallway when (R2) tripped over (R1's) feet. (R2) then yelled, 'you son of a b****' and struck (R1). Staff immediately intervened to separate residents however (R2) was unable to be redirected. Police were notified. (R2) left the facility and started walking on the sidewalk of	S9999		

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S9999	Continued From page 3 road. (V4) followed behind resident with some distance for safety. Police arrived and discussed events with (R2). (R2) transferred to (name of local area hospital) for psych eval per (local police department and EMS)." The facility's "Final Abuse Investigation Report" undated but with a fax submission date of 10/5/22, documents R1 and R2 were in the dining room when R2 struck at R1. No trigger was identified. R2 was sent to the local area hospital for evaluation of increased delusions. This same report documents the local police were notified. R2's Current Care Plan states, "Focus: (R2) has potential to be verbally/physically aggressive r/t (related to) Poor impulse control. (R2) will use racial language directed at staff and peers. (R2) displays a delusional thought process. (R2) is attention seeking at times; may hit/punch himself or bang his head on the wall. (R2) will provoke fights and put himself in a situation to where he can be injured from a fall because he gains attention from staff. (R2) will make false accusations and fabricate stories. (R2) had aggression with weapon. (R2) had an altercation with another peer on 09/03/2022 hitting peer in the eye with a steel mug." The following are documented as interventions for the focused area: When (R2) becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; Allow (R2) to vent his feelings. Encourage (R2) to avoid his source of frustration to prevent escalation; Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document; Assess (R2's) understanding of the situation. Allow time for the resident to express self and feelings towards the situation; Educate (R2) on	S9999		

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S9999	Continued From page 4	S9999		

importance of not calling peers names and risk factors that could occur; Monitor behaviors Document observed behavior and attempted interventions; (R2) on 15-minute safety checks. CNA (Certified Nursing Assistant) to check room for weapons."

On 10/4/22 at 1:15 PM, V4 (Registered Nurse) stated that V4 was R1's nurse on 9/30/22. V4 stated that on 9/30/22 around 8:30/9:00 PM, R1 was being pushed in R1's wheelchair by his roommate (R4) to go to the bathroom before smoke break. V4 stated, at this same time, R2 was walking to get in line against the wall for the smoke break. R2 tripped over R1's foot as R2 was walking to get in line. R2 immediately stated, "You son of a bi****" and immediately punched R1 in the cheek with a closed fist. V4 stated other staff members were present in the main dining room where this occurred and R1 and R2 separated easily but R2 was hard to redirect to stay in building after. V4 stated the police were called and it was determined that R2 would be sent to the local area hospital for a psychiatric evaluation.

On 10/6/22 at 11:51 AM, V4 stated on 9/30/22, V4 stated V4 worked a double shift and V4 saw R2's increased aggressive behavior. R2 threw a tea bottle and was displaying increased yelling and cussing outbursts for approximately three hours before R2 hit R1 in the main dining room. V4 stated that R1 was not the aggressor and that R2 was. V4 stated that it was decided that R2 would be placed on an "informal one-on-one" meaning that there was an understanding that if R2 was in the main common areas, a staff member would have eyes on R2 at all times. V4 denied that no specific staff member was designated to complete the one-to-one supervision for R2. V4

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S9999	Continued From page 5 stated that if R2 was on a "formal one-on-one" it would mean that a specific staff member would be assigned to be within an arm's reach at all times of the resident on one-to-one supervision. V4 stated R2 is known to use racial slurs towards residents and staff. V4 stated, "(R2) is unpredictable, it wasn't that long ago (9/3/22) that he hit the guy (R3) in the eye with a metal cup and broke his face." On 10/4/22 at 1:04 PM, R1 was sitting in R1's wheelchair in the main dining room. R1 was asked about the 9/30/22 incident and R1 stated, "(R2) just walked up and hit me. I was on my way to my room, and he hit me right here on my mouth." At this time, R1 pointed to the left side of R1's lower cheek/chin area near the lip. R1 continued to say, "Been trying to avoid him all day. He always trying to fight me and call me (racial slurs)" On 10/4/22 at 1:07 PM, R4 stated that R1 and R2 are always fighting. R4 stated, "There are fights here all the time, man." On 10/4/22 at 11:28 AM, V2 (Director of Nursing) stated V2 was the weekend supervisor on 9/30/22. V2 stated V2 was made aware by the nursing staff that R2 was having escalating aggressive behaviors and that R2 had hit R1. V2 stated that V2 told the staff, "We need to send (R2) out." On 10/4/22 at 12:23 PM, V8 (Licensed Practical Nurse/LPN) stated that R1 and R2 have to stay apart at all times. "They seem to always clash." On 10/4/22 at 2:45 PM, V7 (Certified Nursing Assistant/CNA) stated, "They (R1 and R2) can't stand the sight of each other. We try and keep	S9999		

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S9999	Continued From page 6	S9999		

them separate as much as we can. If they (R1 and R2) see each other, they are going to fight."

On 10/6/22 at 9:29 AM, V16 (LPN/Restorative) stated, "(R1 and R2) don't get along. They clash every time. We try our best to keep them separated. Some days (R2) is good, and some days (R2) is good at being bad. (R2) has impulse issues. (R1 and R2) are both the same. (R1) does stuff too. If they cross paths, they're going to fight. You can't predict what they are going to do. We can increase supervision on a resident at any time. It is not anything we would need a doctor's order for. If a resident was a one-to-one, someone would be assigned for that resident. (R2's) increased aggression is usually yelling and cussing. We would try to redirect to avoid anything happening. If we can't diffuse the situation, we would then put the resident on one-on-one supervision."

On 10/4/22 at 1130 AM, V12 (Minimum Data Set/MDS Coordinator/LPN) stated, "I've been off the last few days, so I don't know about (R1 and R2's) altercation. We try and keep them separated. Everyone knows when they see each other, it's never good."

On 10/4/22 at 11:16 AM, R2 recalled being in a physical altercation with R1 but could not recall the details. R2 stated, "He (R1) isn't supposed to be within 15 feet of me. I remember being angry and trying to walk away. One of the staff members kept following me. I'm tired of this s*** happening to me."

On 10/6/22 at 11:00 AM, V1 (Administrator) stated that the facility was recently cited at a level of Immediate Jeopardy for R2 hitting R3 in the eye with a metal cup.

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S9999	Continued From page 7 R3's "Accident/Incident Report" dated 9/3/22 at 9:30 PM documents R3 was in a verbal altercation that turned physical. R3 was hit with an object on the left eye and sent to the local area hospital. This same form documents R3 sustained a skin tear and laceration. R2's "Accident/Incident Report" dated 9/3/22 at 9:30 PM documents R2 was in a verbal altercation turned physical. (Cited 9/15/22). (B)	S9999		