FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6007298 B. WING 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3614 NORTH ROCHELLE SHARON HEALTH CARE PINES **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) **Initial Comments** S 000 S 000 Facility Reported Incident of 3/27/23/IL158485 S9999 Final Observations S9999 Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies 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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

plan. Adequate and properly supervised nursing

care and personal care shall be provided to each resident to meet the total nursing and personal

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

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 04/12/2023 IL6007298 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3614 NORTH ROCHELLE** SHARON HEALTH CARE PINES **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 care needs of the resident. Section 300.3210 General The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirments are not met as evidenced by: Based on observation, interview and record review the facility failed to prevent resident-to-resident physical abuse for two of two residents (R1, R2) reviewed for abuse in a sample of nine. This failure resulted in R2 punching R1 in the face causing R1 to have a Periorbital Contusion of the Right Eye which required transfer to the hospital for evaluation and treatment. Findings include: An Abuse Prevention Program Facility Policy dated as reviewed 12/1/22 states, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment." In addition, this policy states, "This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals."

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Further, this policy states, "Abuse means any

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6007298 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3614 NORTH ROCHELLE** SHARON HEALTH CARE PINES **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DÉFICIENCY) S9999 Continued From page 2 S9999 physical or mental injury or sexual assault inflicted upon a resident other than by accidental means." R1's list of current diagnoses includes Intracranial Injury without loss of consciousness; Hemiplegia, unspecified affecting the left dominate side; Unspecified Psychosis not due to a substance or known physiological condition; Anxiety Disorder; Bipolar Disorder. R1's Minimum Data Set (MDS) assessment dated 2/14/23 documents R1 is cognitively intact but with inattention and disorganized thinking which comes and goes and changes in severity. This MDS also documents R1 requires extensive assistance from two people for transfers for most activities of daily living (ADLS). R1's care plan documents R1 has blindness in his left eye related to a Cerebral Vascular Accident and uses a wheelchair as his mode of transportation. R2's list of current diagnoses includes Intracranial Injury without loss of consciousness; Intermittent Explosive Disorder; Brief Psychotic Disorder; Bipolar Disorder, current episode manic severe with psychotic features. Frontotemporal Neurocognitive Disorder, Major Depressive Disorder. R2's MDS assessment dated 3/6/23 documents R2 is severely cognitively impaired with inattention and disorganized thinking which comes and goes and changes in severity. This MDS also documents R2 has physical behavioral

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symptoms directed towards others, which could include hitting, kicking, pushing, scratching, grabbing, abusing others sexually, one to three

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
IL6007298		B. WING			C 04/12/2023	
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
S9999	Continued From page 3		S9999			
	directed towards of In addition, R2's M	verbal behavioral symptoms thers four to six days per week. DS documents R2 requires r walking in his room, in the on the unit.				1%
	documents, "(R2) of inappropriate (behaviors) at time non-compliant of depth of the compliant of descriptions of the compliant of the complian	ed as revised 10/27/21 displays socially/sexually aviors); inappropriate on seeking, child-like s, non-compliance of care, iet, steals food from others, pression, threatens others, tions of others at times, processes."				
	fax transmission re 3/27/23 at approximunwitnessed alteror R2's) room where reside." This report contusion during the investigation was a (Registered Nurse was made aware to from his room with (R1's) room, (R1) stated he was hit (roommate (R2). (FRN went into the re (R1) had been in a and that (R1) has This investigation dated 3/30/23 in wand tore into (R1's included an interviwhich R1 stated, "investigation included."	stigation Report with a dated aport of 3/31/23 states, "On mately 7:20p.m. an ation took place in (R1 and roommate (R1) and (R2) to documents R1 received a his altercation. Included in that a written statement from V6/RN) who wrote, "This RN (V6) that (R1) was yelling for help closed door. This RN went to was laying flat on floor. (R1) punch) in his face by his R2) was not in room when this floom. 911 was called to report altercation with roommate (R2) bleeding from back of head." Included an interview with R2 thich R2 stated, "I had enough," as#!" This investigation also ew with R1 dated 3/28/23 in I got beat up last night." This ided a Domestic Violence to (Police Report) which				

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On 4/12/23 at 9:30a.m. V4 (Certified Nurse Aide) stated that after the altercation between R2 and R1 occurred on 3/27/23, R1 was sent to the hospital. V4 stated that when R1 returned from the hospital R1's face was swollen and bruised

and R1's right eye was swollen shut.

On 4/12/23 at 11:25a.m. R1 was lying in bed waiting for staff to provide cares before going to

PRINTED: 05/17/2023 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING IL6007298 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3614 NORTH ROCHELLE** SHARON HEALTH CARE PINES **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 5 lunch. R1 stated that recently, while he and R2 were roommates, R2 came over to R1's bed and punched him in the face for no reason. R1 stated he had to go to the hospital for treatment. On 4/12/23 at 12:01p.m. V5 (Abuse Coordinator) stated that after the altercation between R2 and R1 occurred on 3/27/23, the police were called and ended up taking R2 into custody. V5 stated that R1 was sent to the hospital for evaluation and treatment. On 4/12/23 at approximately 3:15p.m. V1 (Administrator) stated that he does not believe R2 intended to abuse R1. R2 stated that both R1 and R2 have a history of Traumatic Brain Injuries which makes incidents of hitting and punching just a symptom of their condition and not abuse. When asked if R2's punching of R1 on 3/27/23 was accidental, V1 stated "no." (B) 2 of 2 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies The facility shall have written policies and a) procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy

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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.

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6007298 04/12/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3614 NORTH ROCHELLE** SHARON HEALTH CARE PINES **PEORIA. IL 61604** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 6 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 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. Section 300.3210 General The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirments are not met as evidenced by: Based on observation, interview and record review the facility failed to prevent resident-to-resident physical abuse for two of two residents (R1, R3) reviewed for abuse in a sample of nine. Findings include: R3's list of current diagnoses includes Unspecified Dementia, Paranoid Schizophrenia, Extrapyramidal and Movement Disorder, Major Depressive Disorder, Recurrent.

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SÜRVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: _ B. WING IL6007298 04/12/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3614 NORTH ROCHELLE SHARON HEALTH CARE PINES PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 7 R3's MDS assessment dated 2/2/23 documents R3 is cognitively intact but has inattention and disorganized thinking which comes and goes and changes in severity. R1's list of current diagnoses includes Intracranial Injury without loss of consciousness; Hemiplegia, unspecified affecting the left dominate side; Unspecified Psychosis not due to a substance or known physiological condition; Anxiety Disorder; Bipolar Disorder. R1's Minimum Data Set (MDS) assessment dated 2/14/23 documents R1 is cognitively intact but has inattention and disorganized thinking which comes and goes and changes in severity. R1's care plan dated as revised 7/25/22 documents,"(R1) becomes agitated easily he has behaviors when in dining room and will strike out at peers at times." A Final Abuse Investigation Report dated with a fax transmission report of 12/23/22 states that, "On 12/21/22 at approximately 9:52a.m. in the dining room area male peer, (R1), struck out at peer, (R3), with no injuries noted." This investigation documents that, "Video reviewed showing (R3) in dining room area sitting at dining table. (R3) actively delusional, (with) hands pointing in different directions. (R1) approached table in w/c (wheelchair) and (with) forearm and hand struck (R3's) left side of face. Another peer in the area saw incident and called for staff assistance." This investigation documented by V7 (Social Services) under Informational Report, "Spoke with (R1) regarding incident in dining room with female peer (R3). (R1) stated 'I

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punched her in the face because she was cussing someone out. I was stupid for doing it." This investigation documents an interview with

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