STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	IDENTIFICATION AN IMPED		(X3) DATE SURVEY COMPLETED	
		BETT IOTHOR NOMBER	A BUILDING		COMP	TELED
	IL6007298 B. WING			C 11/01/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SHARON	HEALTH CARE PINE	3614 NOR	TH ROCHE	LLE		
		PEORIA, I	L 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETE DATE
S 000	Initial Comments		S 000			
	Facility Reported In 10-7-23/IL165961.	cident Investigation of				
S99 9 9	Final Observations		S999 9			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210b 300.3210t)					
	•	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisting administrator, the a medical advisory coof nursing and other policies shall complicies shall complicies the facility and shall by this committee, country and dated minutes of Section 300.1210 (19).	dvisory physician or the ammittee, and representatives or services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed of the meeting. Seneral Requirements for				
	b) The facility scare and services to practicable physical well-being of the research resident's complan. Adequate and care and personal of			Attachment A Statement of Licensure Violations		
	ment of Public Health DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE

STATE FORM

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If continuation sheet 1 of 7

EXAMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		IL6007298	B. WING		11/0	1/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SHARON	HEALTH CARE PINE	S PEORIA, I	ITH ROCHEI IL 61604	_LE		
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(XS) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	care needs of the re	esident.				
	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.					
		s are not met as evidenced by:				
	Based on interview and record review, the facility failed to ensure two (R1 and R6) of four residents were free from abuse in a sample of eight. These failures resulted in R1 and R6 both going to the hospital after R1 was struck in the head, and R6 getting a bloody nose.					
	Findings include:					
	Policy, reviewed 9/2 affirms the right of cabuse. Abuse meaninjury or sexual ass Abuse is the willful in unreasonable confine punishment with remental anguish. Phinjury on a resident accidental means a Physical abuse incli	nement, intimidation, or sulting physical harm, pain, or ysical Abuse is the infliction of that occurs other than by nd requires medical attention. udes hitting, slapping, nd controlling behavior				
	documents R1 and yelling at one anoth	ncident, dated 10/7/23 R2 got in a verbal altercation, er, R2 swung at R1, and both other's hair. Altercation lasted Is."				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					С	
IL6007298		B. WING		11/0	1/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	ITATE, ZIP CODE		
SHARON	HEALTH CARE PINE	2	TH ROCHEL	.LE		
		PEORIA, I	L 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 CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(XS) COMPLETE DATE
S99 99	Continued From pa	ge 2	S9999			, and the second
	Facility interview with 10/7/23, documents nurses desk when is R2) were yelling at grab each other's his break them up. (R2) Facility interview with documents "(R1 and all of a sudden out of nowhere and Facility interview with documents "(R2) at to stop talking about pulled (R1's) hair." Facility interview with documents "(R1 and was over immediate and pulled in my busing talking to one anoth talking about me. I head twice and pulled in the results and pulled in the results in the results in the results with talking about me. I head twice and pulled in the results in t	th V6 Registered Nurse, dated is "This nurse was at the screaming was heard. (R1 and each other, they were able to air before staff was able to it) sent to hospital per request." Ith V5 security, undated, it escalated. (R2) just lunged it escalated. (R2) just lunged it got to hair pulling (R1)." Ith R1, dated 10/10/23, pproached (R1) and told (R1) it her. (R2) then struck her and ith R4, dated 10/10/23, id R2) just had a cat fight that				
	R2's medical record R2 is cognitively int	d, dated 9/21/22, documents act.				:
		assessment, dated 9/28/23 triggered, verbal, and physical				

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		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING;		(X3) DATE SURVEY COMPLETED	
	IL6007298 B. WIN		B. WING	B. WING) 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY :	STATE, ZIP CODE		III.UZU
SHAPO	I HEALTH CARE PINE	2844 NOE	TH ROCHE			
SHAROF	HEALIN CARE PINE	PEORIA, I	L 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OTION SHOULD BE OTHE APPROPRIATE	
S9999	Continued From pa	ge 3	59999			
	On 10/31/23 at 2:00 and ambulatory, and me and (R5), we we (R2) thought we we	oppose notes document "altercation oppose notes document "altercation oppose op				
	punched me and pulled my hair. Security (V5) broke it up and I went to the hospital."					
	R1's medical record, dated 8/22/23, documents R1 is cognitively intact.					
	R1's social service assessment, dated 8/21/23 documents "behavioral incidents this quarter, verbally and physically aggressive."					
	R1's 10/7/23 nurses notes document "physical altercation with another resident and sent to the hospital."					
:	R1's 10/7/23 census for payor status.	s report documents "hospital"				
	R1's current carepla regulating emotions	nn documents R1 has "Issues and outbursts."				
	working second shift nurses desk when it the hallway near the frequently, and (R2)	5am, V6 RN stated "I was it on 10/7/23. I was at the happened. It happened in front. (R1) has behaviors does not. (R1) kept passing remarks to her. They were hair."				
		5am, R8 was alert and "(R1) and (R2) got in a cat				
linnis Donor	ment of Public Health					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		IL6007298	B. WING		11/0	; 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SHARON	I HEALTH CARE PINE	S 3614 NOR PEORIA, I	TH ROCHE L 61604	LLE		80
(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 CORRECTM (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
S9999	On 10/31/23 at 12:4 oriented, and stated and pulled her hair. talking about her but and her smoking. (Fewent to the hospital.) On 10/31/23 at 1:00 oriented, and stated Then (R1) and (R8) to (R1) about (R2) go On 10/31/23 at 2:50 worked on 10/7/23 at group of girls (R1) grabbed (R1's) hair, but she probably did seen (R2) with (R1's happened towards the wanted to go to the On 11/1/23 at 9:03at "(R1 and R2) got into went to the hospital. 2. Facility "Prelimina report," dated 9/1/23 involved in a physical bleeding on nose and Facility "Final Abuse 9/6/23, documents"	Spm, R5 was alert and lar(R2) punched (R1) twice (R2) accused me and (R1) of twe were talking about (R8) R1) was the victim here, she large man and large man and large man alert and larg	S9999			
	resulting in (R6) gett	_				
linnis Dener	6:35pm, documents	dent report dated 9/1/23 at "(R7) found (R6) in his room				

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
41					,	
		IL6007298	B. WING		11/0	, 1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CHAROL	I HEALTH CARE PINE	3614 NOR	TH ROCHE	LLE		
SHAROF	I REALIN CARE PINE	PEORIA, I	L 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
S9999	Continued From pa	ge 5	59999		***	
	laying on his bed. (R7) became upset and struck (R6) with closed fist in the face."					
	6:35pm, documents	ident report dated 9/1/23 at s "(R6) struck in face by peer. ing in nose and mouth. Sent				
	Facility interview with R6, dated 9/5/23, documents "I got hit."					
	Facility interview with R7, dated 9/5/23, documents "(R7) stated he struck (R6) in the face."					
	and ambulatory, an lights were off, I dor see flashes in my e bathroom light was open for light. I wen something move; I hallucinating. I askethere, and no one a (R6) in the face. (R6)	ed a couple of time who was inswered. I struck out and hit 6) had to go to the hospital e and talked to me. I told (V1)				
	R7's medical record R7 is cognitively int	I, dated 9/11/23, documents act.				
		an documents R7 is verbally poor impulse control.				
	and ambulatory, and we are friends, I know	I5am, R6 was alert, oriented, d stated "I was in (R7's) bed, ew I was in his bed, we got the nose, and I went to the				
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Illinois Department of Public Health

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
	IL6007298		B. WING		C 11/01/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SHARON	I HEALTH CARE PINE	S 3614 NOR PEORIA, I	TH ROCHEL L 61604	LE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ETE
S9999	Continued From pa	ge 6	59999			
	R6's 9/2/23 nurses	note documents "(R6) ospital after being punched in				
	R6's 9/1/23 census for payor status.	report documents "hospital"				
	,	(B)				
		+ 9Apr				
			0			
			:			
			:			
	report of Dublic Hoolth					

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