STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. Building B. Wing	05/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Health Care Elms	3611 North Rochelle Peoria, IL 61604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to adequately supervise a resident (R1) to prevent resident-to-resident physical abuse for five of five residents (R1-R5) reviewed for abuse in the sample of five. These failures resulted in R1 punching R2 in the left eye, causing a hematoma under R2's left eye and bruising surrounding R2's left eye, and R1 punching R5 in the right arm, causing R5 right arm pain for three days. Findings include: The facility's Abuse Prevention Program policy undated documents, Policy: The facility affirms the right of our residents to be free from abuse, neglect, 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. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment and identifying occurrences and patterns of potential mistreatment. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultations, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. 1. R1's admission Record documents R1 was a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Drug-Induced Subacute Dyskinesia, Schizoaffective Disorder Bipolar Type, Psychotic Disorder with Delusions, Anxiety Disorder, and Adjustment Disorder with Mixed Disturbance of Emotions and Conduct. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 is severely cognitively impaired, displays physical symptoms directed towards other daily (e.g. (for example) hitting, kicking, pushing, scratching, grabbing, abusing others sexually), displays verbal behaviors directed towards others daily (e.g. threatening others, screaming at others, cursing at others) and wanders daily significantly intruding on the privacy or activities of others. R1's current Care Plan documents, (R1) has potential to be verbally and physically aggressive and resistive to cares. Poor impulse control. (R1) will physically fight when staff (are) trying to provide care. (R1) will attempt to physically hit (R1's) peers if they are not able to move out of (R1's) way when (R1) is trying to get by somewhere. (R1) has potential to be physically aggressive to other residents. (R1) displays anger, history of harm to others, and poor impulse control. R1's Progress Notes dated 3-3-25 and signed by V8 (LPN/Licensed Practical Nurse) document, (R1) started hitting on (R2), sitting in a wheelchair and minding (R2's) own business. (R1) started hitting on (R2) causing a hematoma to (the) left lower eye and a scratch to (R2's) left cheek. (R1) and (R2) both separated. (R1) started the incident who is dangerous to staff and other residents. (R1's) behavior is toxic to this facility. R1's Progress Notes dated 3-3-25 and signed by V9 (LPN) document, (R1) kicked and scratched (R3) which made (R3) bleed on (R3's) right upper arm. (R3) has about four scratches that are one cm (centimeter) long. R1's Progress Notes dated 3-16-25 and signed by V3 (RN/Registered Nurse) document, (R1) violent and aggressive towards staff and (R4). R1's Progress Notes dated 4-7-25 and signed by V3 (RN) document, (R1's) wheelchair got caught up with (R5's) wheelchair in the dining room. (R5) stuck her tongue out at (R1) and (R1) slapped (R5) on the right side of the neck. R1's Progress Notes dated 5-28-25 document R1 was admitted to the hospital for treatment of hypoglycemia. On 5-30-25 at 9:30 AM R1 remains in the hospital. 2. R2's admission Record documents R2 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Dementia without Behavior Disturbance, Visual Loss, and Difficulty Walking. R2's MDS assessment dated [DATE] documents R2 is severely cognitively impaired, has no behaviors, and is dependent on staff for ADL's. R2's Accident/Incident Report and Progress Notes dated 3-2-25 at 8:15 PM and signed by V8 (LPN) document, (R2) physically attacked by (R1) causing (R2) a left black eye and a small scratch on (R2's) left cheek and hematoma under (R2's) left eye. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5-31-25 at 10:15 PM V11 (Agency LPN) stated, On 3-2-25 after suppertime I saw (R1) go up to (R2) and punch (R2) several times in the face. (R1) gave (R2) a black eye to the left eye and a knot (hematoma) under the left eye. (R2) is helpless and cannot defend herself. I got in between (R1) and (R2) and was able to take (R1) to her room. (R1) is very abusive and we (facility) staff never know when (R1) is going to get mad and hit someone. 3. R3's admission Record documents R3 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Hemiplegia and Hemiparesis affecting the right dominant side, Generalized Osteoarthritis, Rheumatoid Arthritis, Aphonia (total loss of voice), Anxiety Disorder, and Major Depressive Disorder. R3's MDS assessment dated [DATE] documents R3 is cognitively intact, has no behaviors, and is dependent on staff for ADL's. R3's Accident/Incident Report and Progress Notes dated 3-14-25 at 3:15 PM and signed by V10 (LPN) document, Observed Physical Assault/Altercation. This writer (V10) heard (R3) yell. (V10) walked around the corner and (R1) was swinging (R1's) arms and kicking (R3). After incident (R3) showed (V10) his arm and four skin tears were noted. On 5-30-25 at 11:00 AM R3 was sitting in his room in a wheelchair. R3 was non-verbal and communicated by pointing with his hands and writing on a piece of paper. V3 (RN) was in the room and helped this surveyor to interpret (R3's) handwriting. When this surveyor asked about the altercation between (R1 and R3), (R3) wrote the following on a piece of paper, (R1) is sick in the head. (R1) came up to me for no reason and punched me in both eyes. I tried to block (R1), but (R1) was able to hit me in the eyes. It was painful. When I tried to block (R1), (R1) scratched and pinched both my arms. That hurt worse than the hit to the eyes. When this surveyor asked (R3) if he felt abused by (R1), (R3) shook his head yes.: 4. R4's admission Record documents R4 is a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of Major Depressive Disorder, Delusional Disorders, Mood Disorder, Dementia with Psychotic Disturbance, Visual hallucinations, and Alzheimer's Disease Early Onset. R4's current Care Plan documents R4 is currently receiving hospice services, is totally dependent on staff for ADLs, and is confused. R4's MDS assessment dated [DATE] documents R4 is severely cognitively impaired. R4's Accident/Incident Report and Progress Notes dated 3-16-25 at 12:40 PM and signed by V4 (RN) document, Observed Physical Assault/Altercation. Alleged altercation between another resident (R1) where (R4) was hit in the arm. No apparent injury. On 5-30-25 at 10:15 AM R4 was sitting in a high back fully padded wheelchair. R4 was pleasantly confused and unable to talk. R1 and R4's Witness Statement dated 3-16-25 and signed by V7 (CNA/Certified Nursing Assistant) documents, I was feeding, and I heard (V6/CNA) yelling stop. I (V7) looked up and (R1) was hitting (R4) on the head area and like chest area. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5-30-25 at 10:35 AM V6 (CNA) stated, (R1) and (R4) were eating in the dining room. (R1) rolled up in her wheelchair to (R4) and (R1) was yelling and mad about something. (R1) punched (R4) in the right arm. I removed (R1) to her room. (R4) had no visible injuries. 5. R5's admission Record documents R5 is a [AGE] year-old that was admitted to the facility on [DATE] with the diagnoses of Adjustment Disorder with Depressed Mood, Insomnia, Vascular Dementia without Behavioral Disturbance, and Mood Disorder. R5's MDS assessment dated [DATE] documents R5 is cognitively intact and is dependent on staff for ADL's. R5's Accident/Incident Report and Progress Notes dated 4-7-25 at 7:45 AM and signed by V3 (Registered Nurse/RN) document, Observed Physical Assault/Altercation. (R5's) wheelchair got locked up with (R1's) wheelchair in the dining room. (R5) stuck her tongue out at (R1) and (R1) slapped (R5) on the right side of the neck. No apparent injury. On 5-30-25 at 11:00 AM R5 was sitting in a wheelchair in the dining room. R5 stated, (R1) hit me over a month ago. (R1's) wheelchair tire got hooked on my tire and (R1) got mad and hit me in the right arm three times. I was in pain for three days after that. I have arthritis all over. (R1) should not be able to hit me. That is abuse. On 5-30-25 at 2:00 PM V3 (RN) stated, (R1) is out of control and needs supervised by staff at all times. On 4-7-25 (R1) and (R5's) wheelchairs got locked together and (R1) hit (R5) for no reason. On 5-30-25 at 2:10 PM V1 (Administrator) stated, All of the altercations from R1 to R2, R3, R4, and R5 are physical abuse.