STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E322	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Health Care Pines	3614 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. 33973 Based on observation, interview, and record review, the facility failed to ensure a resident (R2) was free from physical abuse by another resident (R1) for two of four residents reviewed for abuse in a sample of four. This failure resulted in R2 receiving sutures at the hospital for a facial laceration. Findings include: The facility's undated Abuse Prevention Program Facility Policy documents Policy: 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. 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 policy continues to state, 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. This policy also states Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. Abuse: 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 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. R1's current Face sheet documents diagnoses including, but not limited to Psychotic disorder, Mood disorder, Unspecified Dementia, Anxiety, and Traumatic Brain Injury/TBI. R1's Minimum Data Set/MDS Assessment, dated 11/11/24, documents R1 has fluctuations of inattention and disorganized thinking and is severely cognitively impaired. (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 Care plan includes but is not limited to (R1) can become verbally and physically aggressive due to TBI (Traumatic Brain Injury) diagnosis. (R1) is delusional and feels he can care for himself. (R1) displays poor planning, poor insight judgment and decision-making ability, poor stress and emotion management, poor impulse control, and poor coping skills. R1's Progress note, dated 11-15-24, documents Resident was in altercation with peer (R2). This RN (Registered Nurse) did not witness altercation. Per report, resident swung right hand striking (R2) in the face. On 12/6/24, at 11:55am, R2 sat in the TV (television) area with a suture line noted to his left cheek. R2 did not recall being hit or having any altercation with another resident (R1). R2's current Face sheet documents diagnoses including, but not limited to Unspecified Dementia, Anxiety, and Schizoaffective disorder, depressive type. R2's Minimum Data Set/MDS Assessment, dated 9/30/24, documents R2 has fluctuations of inattention and disorganized thinking and is moderately cognitively impaired. R2's Care plan includes but is not limited to (R2) displays (episodes) of verbal aggression, physical aggression, and agitation related to being over stimulation and to misinterpretation of others and situations. He displays poor decision making and poor impulse control. R2's Progress note, dated 11-15-24 by V5 Registered Nurse/RN, documents Resident was involved in an altercation. Resident was in the TV area, him and another peer (R1). First, they started arguing. As another nurse and I went to intervene to separate them, the other resident (R1) stood up and swung before we could stop him (R1). Resident (R2) has a wound on the left side of the cheek. This nurse applied pressure to wound to stop bleeding and area was cleaned. The patient (R2) was sent to (named hospital) for further evaluation. R2's progress note, dated 11-15-24, documents Resident returned from (named hospital) around (6:35pm). Laceration repair L (left) side of face; stitches to be removed in 7-10 days. The facility's abuse reportables include an altercation between R1 and R2; witness included V4 Certified Nurse Assistant/CNA and V5 Registered Nurse/RN. The Final Report, dated 11-20-24, by V3 Abuse Coordinator, documents the following: Residents (R2 and R1) sitting in TV dining room area 11-15-24 at approximately 2:45pm watching television. Video (camera) was watched. (R2) made a lunge like movement from his chair toward (R1). (R1) stood up from his chair and struck (R2). (R2) sent to hospital with a laceration on the left side of face. (R1) had superficial scratch on right hand. On 12/6/24, at 11:46am, V4 CNA stated the following: (On 11/15/24) I was behind the desk, and I saw (R2) yell at the TV. Then (R1) yelled. (R1) stood up so I tried to calm (R1) down. (R1) started hitting (R2) so I moved (R1) away from (R2). R2's face was bleeding. V4 continued to state (R1) was intentional and knew who his target was. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/6/24, at 11:51am, V5 RN stated the following: (On 11/15/24) I remember those two (R1 and R2) were sitting beside each other .Yelling was going on by (R2). (R1) gets very agitated with loud noises, banging and yelling. (R1) doesn't like it close to him and gets agitated. (R1) yelled and then stopped. I walked away from nurses' station then it started again. Now (R1) was standing up, when (R1) stood up staff tried to intervene, but (R1) had hit (R2) before we reached them. (R1) hit (R2) on the left side of (R2's) face and it was bleeding. At this time V5 confirmed (R1's) strike was on purpose and stated, 'Oh, he hit him.' On 12/10/24, at 11:53am, V3 Abuse Coordinator stated that V3 reviewed the video camera to see what had happened. V3 stated on 11/15/24, R1 and R2 were in the TV area talking and next thing (R1) got up and hit (R2) in the face. V3 stated R1 and R2 are very impulsive and reactive. There is no pre-meditation. They have no impulse control. Never know when those things are going to happen. V3 confirmed it was not an accident.