

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Sharon Health Care Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33975</p> <p>Based on interview and record review the facility failed to protect a resident (R1) from mental and verbal abuse and failed to protect residents from further potential abuse. This failure resulted in residents experiencing emotional distress and persistent fear of V3 (Certified Nursing Assistant). This failure has the potential to affect all 102 residents who reside in the facility.</p> <p>This failure resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on 3/19/25 at approximately 5:00 pm, when V3 (Certified Nursing Assistant/CNA) responded inappropriately to R1. V3 taunted R1 by sticking her tongue out at R1; calling R1's significant other ugly; and asking if R1 was going to fight V3. R1 experienced emotional distress and fear of V3. V3's termination was rescinded and V3 returned to work in the facility, leaving residents fearful.</p> <p>While the immediacy was removed on 4/24/25, the facility remains out of compliance at Severity Level II as additional time is needed to evaluate the implementation and effectiveness of their removal plan and Quality Assurance monitoring.</p> <p>Findings include:</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Facility Abuse Prevention Program Facility Policy, reviewed 12/18/24, documents: the Facility affirms the right to our Residents to be free from abuse and neglect; prohibits mistreatment, neglect or abuse of its Residents, and has attempted to establish a Resident sensitive and secure environment; purpose of this policy is to assure that the Facility is doing all this within its control to prevent occurrences of mistreatment, neglect or abuse of our Residents; by orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of mistreatment, neglect and abuse; establishing an environment that promotes Resident sensitivity, security and prevention of mistreatment; identifying occurrences and patterns of potential mistreatment promptly and aggressively and making the necessary changes to prevent future occurrences; committed to protecting our Residents from Abuse by anyone including, but not limited to Facility staff, other Residents and staff from other Agencies, or any other individuals; this Facility will not knowingly employ individuals who have been convicted of abusing, neglecting or mistreating individuals; the following are based on Federal and State Regulations and interpretive guidelines; verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to Residents, within their hearing distance, regardless of their age, ability to comprehend, or disability; example of verbal abuse include, but no limited to, threats of harm or saying things to frighten a Resident; and mistreatment means inappropriate treatment.</p> <p>The Facility Resident Rights for People in Long-Term Care Facilities, revised 3/2011, documents: Your Facility must provide services to keep your physical and mental health and sense of satisfaction and you must not be abused by anyone, physically, verbally or mentally.</p> <p>The Facility Diffusing Behaviors Policy, undated, documents: do not raise voice; do not argue, scold or threaten; do not treat patients like they are your children, do not be condescending; do not talk about patients in his/her presence; and do not take it personally and get upset; do remain calm; do intervene early; do not try to reason with someone who is unreasonable; and do take time to listen.</p> <p>The facility's current Room Roster documents 102 residents currently reside in the facility.</p> <p>The Facility's local Report to the State Agency, dated 3/25/25, documents an Abuse incident on 3/19/25 between R1 and V3 (CNA). The Final Report documents an event that occurred in the Main Dining Room. R1 and V5 (Registered Nurse/RN) were discussing R1's request for a wheelchair to assist temporarily with mobility issues, when V3 (CNA) interrupted the conversation to comment that (R1) was not having any kind of difficulties with mobility earlier when your new girlfriend was visiting, then R1 told V3 to shut up, and called V3 a bitch. R1 stated, I am not talking to you (V3). V3 proceeded to tell R1 your girlfriend is ugly. R1 got upset and V3 remained argumentative and confrontational, raising both arms into fists, saying What are you going to do about it? Fight me?</p> <p>The Facility's local Report to the State Agency, dated 3/25/25, documents an interview with R1. R1 stated that while R1 was at the Nurse's Station, R1 was talking to V5 (Registered Nurse) and V3 (CNA) stated to me by the way, your girlfriend is ugly. So R1 stated, no she is not. R1 also stated, I also could have said more to her, but I do not recall. Then R1 stated that (V3) started to stick her tongue out and stated, I am going to take away your visitor pass and V3 was making threatening gestures.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R1's Information Report, dated 3/21/25 at 1:45 pm, documents that V3 (CNA) told R1, Your girlfriend is ugly. R1 stated, Look, she is not ugly, she is beautiful. V3 then stuck her tongue out at (R1) three times.</p> <p>V1's (Administrator/ADM) Information Report, undated, documents that it was difficult getting V3 to write a statement regarding the incident with R1. V1 documents that V3 was very confrontational and aggressive. The Information Report also documents that V3 was fixated on wanting to know what was being done to (R1) personally and how (R1) was going to be punished for cussing at (V3). V1 attempted to explain to V3 that the Facility does not punish Residents and that the Resident population in the Facility has mental illnesses or brain injuries and consequently may have behaviors. V3 remained argumentative with minimal insight.</p> <p>V3's (CNA) Information Report, dated 3/19/25, documents that R5 was helping R1 walk, and V3 stated that V3 jokingly said to R5, Why are you holding her arm? She can walk. R1 told V3 to shut up. V3 then stated to R1, I was not even talking to you, why are you even talking to me? R1 told V3 because I can. V3 stated, that is when I said 'girl' by the way, yo (your) girlfriend ugly.</p> <p>V5's (Registered Nurse/RN) Informational Report, undated, documents that R1 was talking to V5 about obtaining a wheelchair. V5 stated (V3) 'chimed' in and responded to R1. R1 responded to V3 stating you are not my nurse or CNA so shut up. V5 then proceeded to ask R1 to calm down and go back to R1's hall. Then V3 proceeded to call (R1's) girlfriend ugly. R1 then called V3 a b*tch. V3 then responded to R1 fight me, fight me. V5 states that the staff grabbed (R1) and (V3) and proceeded to tell them to let her (R1) go. R1 went down the hallway. V5 stated that V3 was inappropriate and R1 told V5 that R1 felt disrespected and that R1 is afraid of (V3) when (V3) works down (R1's) hallway.</p> <p>V6's (Registered Nurse/RN) Informational Report, undated, documents that V3's response to R1 was over-the-top and inappropriate. R1 wanted to sit in a wheelchair because R1's foot hurt. V3 stated, you was not hurting earlier. R1 told V3 to shut the f*** up b****, I was not talking to you. V6 states that R1 was tired of being interrupted by (V3). V3 then told R1 well, your girlfriend is ugly. V6 stated that V3 would not stop and kept saying what (are) you gonna do about it? and like (V3) was trying to get (R1) to fight. V6 stated that V3's behavior was inappropriate and unprofessional.</p> <p>V7's (Registered Nurse/RN) Informational Report, undated, documents that V3 is confrontational, demeaning to the Residents and just talks down to them. V7 also stated that V3 acts like she does not provoke them (Residents) on purpose.</p> <p>V8's (Licensed Practical Nurse/LPN) Informational Report, undated, documents that V8 reports that V3 is borderline rude and not appropriate with Residents. V8 also reports that V3 is often confrontational with residents and talks down to them.</p> <p>V10's (Certified Nursing Assistant/CNA) Informational Report, undated, documents that V3 was grossly inappropriate and unprofessional. V10 also states that V3 presents as confrontational and argumentative with Residents.</p> <p>The Facility Nursing 24 Hour Staffing Reports (dated 4/1/25, 4/2/25, 4/3/25, 4/5/25, 4/6/25, 4/9/25, 4/10/25, 4/14/25, 4/15/25, 4/17/25, 4/19/25 and 4/20/25) document V3 (CNA) working Second Shift on the B Hall, C Hall, E Hall and Kitchen Window.</p> <p>(continued on next page)</p>		

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