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	05/20/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50430 Based on interview and record review the facility failed to investigate an incident when residents were exposed to a toxic chemical and failed to follow their policy regarding Safety/Supervision related to Incidents/Accidents. The facility failed to perform and document an individual assessment after a resident was known to have been exposed to a toxic chemical for one of three residents (R2) reviewed for quality of care and treatment in the sample of three. Findings include: The facility's undated Incidents/Accidents Policy and Procedure documents an accident is an unexpected, unintended event that can cause a resident bodily injury. An Incident is any occurrence that could result in physical harm or great emotional upset to a resident. Each incident or accident must be detailed in the medical record of the involved resident. This includes drug reactions or any happening or experience which may be traumatic or inflict bodily injury to a resident. This policy further documents a nurse will assess the resident's condition and if an injury or suspected injury results, will notify the physician and follow the specific treatment plan. The nurse will document the event in the residents' individual clinical record and an incident/accident report will be written and given to Director of Nursing upon completion. R2's current Minimum Data Set Assessment documents R2 is cognitively intact. On 5/20/25 at 9:45 AM, R2 stated (on 4/14/25), R2 was in the dining room eating supper. I remember my eyes began burning and I was coughing, but I didn't know what was going on. R2 stated residents were being evacuated out of the facility because a can of [NAME] went off in the dining room. R2 denied being assessed by a nurse after the incident. As of 5/20/25, R2's medical record did not contain documentation of the 4/14/25 incident and did not contain documentation that a nursing assessment was completed on R2 after. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 2:51 PM, V10 (Registered Nurse/RN) stated V10 had a small can of [NAME] on a keychain. V10 stated V10 was standing in the dining room and the can of [NAME] accidently went off. V10 further stated there were some residents in the dining room who started coughing, so V11 (RN) called 911. V10 stated the staff took the residents outside for fresh air until the fire truck and ambulance came. V10 stated the police were going to call in a biohazard team to investigate until V10 told the police V10's can of [NAME] accidently went off. V10 confirmed V10 was R2's nurse on 4/14/25 and verified V10 did not complete any resident assessments. On 5/19/25 at 1:39 PM, V8 (Registered Nurse/RN) stated on 4/14/25, V11 (RN) called V8 and stated, something is going on with the residents, they are coughing and nauseous. V11 began moving the residents outside and called 911. V8 stated the police came to the facility and later determined a can of [NAME] had gone off. V8 stated residents were present in the dining room at the time but could not recall who. V8 verified V8 did not complete an Incident Report or any resident assessments after the 4/14/25 incident. On 5/20/25 at 9:30 AM, V4 (Licensed Practical Nurse) stated V4 saw an orange substance in the air and staff members started coughing. V4 stated the staff didn't know immediately what happened. V4 stated residents were eating supper in the dining room at the time. V11 (RN) called 911 and the residents in the dining room were evacuated to the outside. V4 verified V4 did not complete an Incident Report or document any resident assessments after the 4/14/25 incident. On 5/20/25 at 11:36 AM, V11 (RN) stated on 4/14/25, V11 was in the hallway passing medications. V11 stated a staff member began yelling to not go to the dining room. V11 went to look and see what was happening. V11 started coughing and stated many residents were coughing. V11 yelled to evacuate because V11 had no idea what was happening. V11 called 911 and V1 (Administrator) immediately. V11 stated V11 filled out an Incident Report but believes it was destroyed. V11 stated the incident was not investigated. On 5/19/25 at 2:01 PM, V2 (Director of Nursing) stated V10 (RN) was given the can of the [NAME] from an unknown nurse. On 4/14/25, V10 accidently dropped the can of [NAME] on the dining room floor, causing it to go off. V2 stated the staff evacuated residents outside. V2 stated the police and fire department came and ultimately gave all clear for everyone to come back inside. V2 stated nursing assessments should have been completed and documented on the residents in the dining room at the time, but they were not. On 5/20/25 at 9:15 AM, V3 (Quality Assurance) stated V3 was unable to find an Investigation, Witness Statements, or an Incident Report for the can of [NAME] going off in the dining room of the facility on 4/14/25. V3 further stated V3 is unable to find any assessments or documentation completed on the residents who were exposed in dining room. V3 stated V1 (Administrator) is currently out of the country. V3 stated V3 called V1 to find information on the 4/14/25 incident and V1 stated V1 came to the facility at the time of the incident on 4/14/25, but that V1 did not complete an investigation. As of 5/20/25, the facility was unable to state what residents were in the dining room at the time of the 4/14/25 incident and the facility was unable to provide documentation that an Investigation or Incident Report had been completed.