| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14E322 | A. Building<br>B. Wing | 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sharon Health Care Pines | 3614 North Rochelle<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Based on record review and interview, the facility failed to protect a resident from physical abuse for two of four (R1 and R3) residents reviewed for abuse in a sample of four. This failure resulted in R1 sustaining a complex fracture of the left hip requiring surgical intervention. Findings include:The facility's Abuse Prevention Program, reviewed 7/21/25, documents that 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. This form also documents that willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention.R1's electronic medical record documents the following diagnoses: Schizophrenia, Major Depression, Dementia, EPS, HTN, Thrombocytopenia, GERD, Hypercholesterolemia, BPH, Dysfunction of the bladder, chronic kidney disease stage four. R1's current care plan documents that R1 is delusional daily. He also experiences auditory hallucinations to which he responds. Often, he becomes agitated at the voices and will yell and curse.R1's Brief Interview for Mental Status, dated 5/5/24, documents a score of 14, indicating the R1 is alert and oriented to person, place, and time.R1's Progress Notes, dated 7/22/25, document that resident (R1) was involved in an altercation with a peer (R2) while outside on the smoking patio. (R1) was lying on the patio, stating his hip hurt. (R1) was lying on his left side near his wheelchair on the pavement of the smoking patio. (R1) stated that his right hip hurt; however, he was lying on his left side. (R1) stated that he was unable to stand up due to the pain. Orders were received to send (R1) to the emergency room for an evaluation.R1's emergency room Notes, dated 7/22/25, document that R1 presented after a ground-level fall when one of the residents of his nursing home pushed him out of his wheelchair and he fell to the ground on his left side, leading to a complex left hip fracture. The Patient states that he does not want to return to the SNF (skilled nursing facility) because of the other residents. R1's Radiology Report, dated 7/22/25, documents a complex fracture of the left hip including both intertrochanteric and suspected basicervical components. Femoral foreshortening and coxa vera deformity at the left hip. R2's electronic medical record documents the following diagnoses: Encephalopathy, Diverticulosis, Mood Disorder, Paraphilia, Seizures, Heart Disease, Chronic Embolism and Thrombosis, Toxic effect of alcohol abuse, and Obsessive Compulsive Disorder.R2's current care plan documents that R2 has a behavior problem: (R2 has a history of socially inappropriate behaviors. (R2) can be verbally and physically aggressive, intrusive, and property destruction. (R2) displays a delusional thought process as to his limitations and effects on self, others, and surroundings, as well as the safety of self and others.R2's Progress Notes, dated 7/22/25, document that R2 had an incident with a peer (R1) this morning. (R2) stated that the peer (R1) was Saying stuff that pissed me off and that's all I'm going to say.On 7/25/25 at 10:45am, R4 stated that R1 and R2 were bickering back and forth on the patio. R4 stated that all of a sudden, R2 got up and dumped R1 out of the wheelchair onto the concrete.On 7/25/25 at 11:00am, R3 stated that R1 was sitting in his wheelchair with his back to the wall, confused and yelling out. R3 also stated that R2 was sitting with his back to R1, yelling back at R1. R3 stated that R2 got tired of listening to R1, so R2 got up, pushed R1's wheelchair in front of the patio door, and tipped him out of the wheelchair. R3 stated that he got between R1 and R2. R3 stated that he got punched in the face during the altercation. R3 verified that R1 was yelling in pain and could not get up.On 7/25/25 at 1:00pm, V3, Administrative Quality Assurance/Grievance/Abuse Coordinator, stated that the majority of the resident population has a traumatic brain injury, so they are impulsive. V3 stated that this incident was an impulse, not abuse. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and record review, the facility failed to notify local law enforcement of a resident-to-resident physical altercation resulting in an injury, for one of two residents (R1) reviewed for reporting abuse in a sample of four. The facility's Abuse Prevention Program Facility Procedures, reviewed 7/21/25, documents that the facility shall contact local law enforcement authorities (i.e., non-emergency police number or 911) in the following situations: Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability.R1's Progress Notes, dated 7/22/25, document that resident (R1) was involved in an altercation with a peer (R2) while outside on the smoking patio. (R1) was lying on the patio, stating his hip hurt. (R1) was lying on his left side near his wheelchair on the pavement of the smoking patio. (R1) stated that his right hip hurt; however, he was lying on his left side. (R1) stated that he was unable to stand up due to the pain. Orders were received to send (R1) to the emergency room for an evaluation. R1's Radiology Report, dated 7/22/25, documents a complex fracture of the left hip including both intertrochanteric and suspected basicervical components. Femoral foreshortening and coxa vera deformity at the left hip.R2's Progress Notes, dated 7/22/25, documents that R2 had an incident with a peer (R1) this morning. (R2) stated that the peer (R1) was Saying stuff that pissed me off and that's all I'm going to say. On 7/25/25 at 1:00pm, V3, Administrative Quality Assurance/Grievance/Abuse Coordinator stated that the local police were not notified of the incident between R1 and R2. |