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	06/25/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to prevent abuse of five (R2, R4, R5, R6, R7) of 7 residents reviewed for abuse. This failure resulted in R1 picking up a chair and hitting R2 in the head causing R2 to go unconscious, sustaining a bleeding laceration to upper lip requiring sutures and sustaining a laceration to left side of head requiring three staples. Findings include:The facility policy, Abuse Prevention Program Facility Procedure, reviewed 9/1/25, documents not in its entirety, This facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing a resident sensitive and resident secure environment.1. Facility incident report dated 5/24/26 documents that R1 and R2 got into a physical altercation after R2 became agitated at R1 over table seating in the dining room. R1 asked R2 to go to another table causing R2 to strike out at R1 and R1 picking up a chair and hitting R2 in the head causing R2 to go unconscious and receive 2 lacerations requiring medical intervention of sutures and staples at local hospital.R1's admission record documents R1's date of admission to the facility was 1/29/24 and his diagnoses included but are not limited to: Major Depressive Disorder, Recurrent, Schizoaffective Disorder, Cocaine Abuse, Anxiety Disorder, Anoxic Brain Damage, Hypertension, Cerebrovascular Disease and Personal History of Traumatic Brain Injury.R1's Minimum Data Set (MDS) assessment dated [DATE] documents R1 has a BIMS (Brief Interview of Mental Status) score of 12/15, indicating cognition is moderately impaired, has delusions and has had no behavioral symptoms.R1's current care plan documents R1 has impaired cognition and thought processes related to head injury, impaired decision-making, short-term memory loss, and poor impulse control.On 6/16/26 at 10:30am, R1 stated that on 5/24/26 he was sitting at the dining room table that he always sat at when R2 came up to him. R1 asked him to leave and R2 gave him the middle finger so R1 asked R2 again to leave and R2 told R1 to F*** off, came toward R1 and hit him. R1 stated at this point it angered him, so he picked up a chair and hit R2 with it. I got arrested and he (R2) went to the hospital. When I got back to the facility I was moved to a different room across the building from him (R2), placed at a different seat in the dining room away from him (R2) and they (management) asked me if I want to move to another facility and I told them yes so we are waiting on my mom to approve the move.On 6/24/26 at 11:40am, V4 (Registered Nurse) stated on 5/24/26 she was sitting at the nurse's station that oversees the dining room doing some charting right before supper. I happened to look up and saw R2 sitting in his wheelchair facing toward the kitchen doors in front of the table against the wall. (R2) had his hand up as if he was going to hit (R1) and (R1) was pushing (R2) away so I got up and was yelling to (R2) NO as I was going toward them. Before I could get there (R1) picked up a chair and hit (R2) in the head with it. The other nurses working, (V5/Registered Nurse) and another one I don't recall were already with (R2) and (R1) started walking away. I went back to the desk and called the police and the ambulance and as (R1) was walking by the desk I told him that he was going to go to jail, and the police had already been called. I finished notifying everyone and doing the paperwork to send out (R2) to the hospital. It all happened so fast.On 6/24/26 at 12:24pm V7 (Certified Nursing Assistant) stated on 5/24/26 he was going into the kitchen when he heard (R1) state get away from (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	me. (R1) is pretty chill, so I didn't think anything of it and did not know he was talking to (R2). I went into the kitchen at which point I heard a loud bang. I came back out of the kitchen and saw that the residents were already separated, a nurse (unsure which nurse) was holding towels to (R2)'s head and (R1) was walking away from the table. (R2) was pretty messed up, he had a cut to his nose, looked like he had some broken teeth, and he had a cut to the side of his head. (R2) will usually leave when you tell him to, but he is also known to hit people and (R1) isn't known for hitting unless he is hit.R2's admission record documents R2's date of admission to the facility was 12/2/16 and his diagnoses included but are not limited to: Intracranial Injury without loss of Consciousness, Alcohol Abuse, Bipolar Disorder, Current Episode Manic without psychotic features, Sleep Terrors, Personal History of Traumatic Brain Injury, Anxiety Disorder, Restlessness and Agitation, and Hemiplegia Affecting Left Dominant Side.R2's Minimum Data Set (MDS) assessment dated [DATE] documents R2 has a BIMS (Brief Interview of Mental Status) score of 4/15, indicating cognition is severely impaired, vision is moderately impaired, has delusions and has no behavioral symptoms.R2's current care plan documents R2 has a behavior problem verbal/physical aggression, threatening language, resistive to care related to cognitive impairments, delusional thought process, poor planning, poor insight/judgement, and emotion management poor coping skills and impulsivity. R2's current care plan also documents that R2 has impaired vision related to blindness in left eye.On 6/16/26 at 3:00pm, R2 stated three weeks ago another resident (does not recall who) punched me on the left side of my face, I have a scar now and am blind in this eye (points to left eye). R2 stated that he does not recall why the other resident hit him, but he's not here anymore. When R2 was asked if he feels safe in the facility he stated, No I don't. I'm scared. I watch the room constantly for him (referring to the other resident). It makes me scared he is coming back. The staff didn't do anything, just let him beat me and I went to the hospital for three weeks.On 6/24/26 at 1:30pm, V4 (Abuse Coordinator) stated she does not recall exactly what all happened but knows that R1 and R2 got into a physical altercation in the dining room over table seating. R1 told R2 to move, which agitated R2 causing R2 to roll his wheelchair over to R1 and strike out at him. R1 then got up and hit R2 with a chair. Staff immediately intervened, R1 got up and went to his room, R2 went to local hospital for treatment of his injuries and R1 was arrested. Upon R1's return to the facility he was moved to a room across the facility from R2 and he was moved to a different table across the room from R2 in the dining room. Counseling R1 to manage his behaviors, both care plans reviewed and updated, and nursing notified of interventions placed. When asked if V7 (Certified Nursing Assistant) should have intervened when hearing R1 say get away from me, V4 stated, We know our residents here and we know which ones need us to intervene right away. R1 wasn't known to be physically aggressive. V4 also stated, Whatever is in the facility report is the most accurate information as I cannot recall every detail of the incident.2. On 6/24/26 Final State Investigation to facility reported incident dated 6/10/26 documents, (R3) became agitated with (R4) in the TV (television) area in the Main Dining Room and became physically confrontational. Staff immediately intervened and separated the clients. (R3) was counseled and escorted to his personal room as an environmental intervention. A few minutes later, (R3) struck out at his roommate (R5), walked out of his room and became physically aggressive with other peers (R6, R7). Staff immediately intervened and separated all of the involved parties to ensure the safety of all individuals involved.R3's admission record documents R3's date of admission to the facility was 6/1/26 and his diagnoses included but are not limited to: Schizoaffective Disorder Bipolar Type, Anxiety Disorder, Insomnia, Alcohol Abuse, Hypothyroidism, and Patient's Noncompliance with other medical treatment and regimen due to unspecified reason.R3's Minimum Data Set (MDS) assessment dated [DATE] documents R3 has a BIMS (Brief Interview of Mental Status) score of 10/15, indicating cognition is moderately impaired, has hallucinations, delusions and has had behavioral symptoms of rejecting care.R3's current care plan documents R3 has recent history of refusing treatment, verbal aggression, increased agitation, responds to hallucinations, difficulty thinking through or completing task, serious difficulty interacting with others related to delusional thinking and he has impulse (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	control deficits.On 6/24/26 at 10:40am, V15 (Licensed Practical Nurse) stated on the morning of 6/10/26 he was finishing his medication pass when he heard a commotion coming from the dining area. V15 went to the dining area and a CNA (Certified Nursing Assistant) came to me, not sure who it was, and said (R3) was attacking people and they needed my help since I was the only male in the building. At this time a resident who I was told was (R5) came to the doorway over by the pool table room stating to call the police because his roommate just hit him. I went down to help and that's when I saw staff bringing (R3) up the hallway to the day room. Security (V12) came and made (R3) sit down on the floor until the police got here but (R3) got up and hit (R6). V12 was able to separate them and made (R3) sit back down. Police arrived and stood (R3) up and were escorting him out of the building when I saw (R7) walking by (R3) saying something like why you hit me, I don't recall exactly what he (R7) said but something along those lines. I saw (R3) get away from the police and head toward (R7), but I was able to move (R7), and the police got to (R3) and then handcuffed him (R3) and escorted him out of the building.On 6/24/26 at 12:48pm, V11 (Licensed Practical Nurse) stated that she was working on 6/10/26 when R3 became physically aggressive toward multiple peers. V11 stated approximately 5:15am on 6/10/26 R4 came to the television lounge per his usual routine and V11 was at the nurse's station across from the lounge charting. V11 heard R4 scream and looked up to see R3 hitting R4. V11 immediately intervened, assessed R4 for injuries with none noted and yelled for V12 (Security) who was in front of the building. V12 came down to the lounge and assisted V11 in walking R3 back to his room to separate him from R4. V12 stayed and talked with R3 for a couple of minutes before going back to the front desk and V11 went back to the nurse's station to finish her medication pass. V11 stated approximately 5 minutes later R5 came up to her stating to call the police because his roommate had just hit him. V11 assessed R5 for injuries with none noted and V14 (Certified Nursing Assistant) went down to check on R3. V11 then followed to check on R3 and noted V14 walking R3 up the hallway and V14 told V11 that she noted R3 going into R7's room and when she got to him, he was hitting R7. V11 stated by this time V12 had come down the hallway and all three of them (V11, V12, V14) took R3 to the lounge and R3 then went after R6 attempting to hit him, V11 stated, I don't think he hit R6 but I'm not sure. I grabbed R3 and along with V12 we did a CPI (Crisis Prevention Institute) hold and got R3 to sit on the floor by the vending machines. Police were called and came as well as the ambulance to take R3 for a psychiatric evaluation. V11 stated that the police told her that they could not take R3 for a psychiatric evaluation without involuntary discharge paperwork so V2 (Director of Nursing) was called and stated she was on her way to the facility. As police were walking R3 to the front of the building R3 attempted to go after R7 again, so the police handcuffed R3 and escorted him out of the building.On 6/24/26 at 2:43pm, V12 (Security) stated he was sitting at the front desk by the entrance of the building when he heard someone calling for security from the dining room. V12 got up and went down to the dining room and noted R3 hitting another resident (unsure of resident name). V12 walked R3 to his room, before V12 left R3 came out of his room talking about prisoners beating up and killing his girlfriend, V12 talked with R3 and calmed him before heading back up to the front of the building. V12 heard someone yelling for security again so he went back down and witnessed R3 hit another resident (unsure of this resident's name also) so assisted in getting R3 to sit on the floor until police arrived. Police were walking R3 to the front of the building and V12 heard R3 telling the police about the prisoners raping, beating and murdering his girlfriend. I didn't see R3 once they got him out of the building. All in all, I believe R3 hit four or five other residents before he left the building, but I only saw him hit 2 and I am not good with remembering the resident's names.R4's admission record documents R4's date of admission to the facility was 8/14/98 and his diagnoses included but are not limited to: Schizoaffective Disorder, Major Depressive Disorder, Recurrent, and Convulsions.On 6/25/26 at 9:15am, R4 stated he recalls being hit by someone, does not remember who but stated, I'm fine.R5's admission record documents R5's date of admission to the facility was 9/30/19 and his diagnoses included but are not limited to: Encephalopathy, Intermittent Explosive Disorder, Mood Disorder due to known Physiological condition (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	with Manic Features, Obsessive-Compulsive Disorder, Paraphilia, and Acute Ischemic Heart Disease.On 6/25/26 at 9:18pm, R5 stated he does not remember being hit by anyone.R6's admission record documents R6's date of admission to the facility was 9/14/21 and his diagnoses included but are not limited to: Other Specified Intracranial Injury without Loss of Consciousness, Anemia, Major Depressive Disorder, Recurrent, Anxiety Disorder, Intermittent Explosive Disorder, Anoxic Brain Damage, and Post Traumatic Seizures.On 6/25/26 at 9:20am, R6 stated, Nobody has tried to hit me or have hit me here that I can remember.R7's admission record documents R7's date of admission to the facility was 2/15/18 and his diagnoses included but are not limited to: Other Specified Intracranial Injury without Loss of Consciousness, Cannabis Abuse with Intoxication, Schizoaffective Disorder Bipolar Type, Frontotemporal Neurocognitive Disorder, Bipolar Disorder, and antisocial personality disorder.On 6/25/26 at 9:30am, R7 stated, I remember a guy hitting me because I asked for a cigarette, but I don't remember when that was or who he was. I haven't had any issues since.On 6/24/26 at 1:30pm, V4 stated when asked about the incident involving R3, What is in the facility report is accurate. R3 hit multiple peers and was taken to the hospital for a psychiatric evaluation. R3 discharged home from the hospital and will not be returning to the facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report a resident-to-resident abuse allegation to the state agency for one (R1) of seven residents reviewed for abuse. Findings include:Facility policy, Abuse Prevention Program Facility Procedures, reviewed 9/1/25, documents not in its entirety, Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated. The report shall include the following information, if known at the time of the report: Name, age, diagnosis and mental status of the resident allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated, type of abuse reported (physical, sexual, neglect, verbal or mental abuse, misappropriation of resident property), date, time, location and circumstances of the alleged incident, any obvious injuries or complaints of injuries, steps the facility has taken to protect the resident. This report shall be made immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or resulted in serious bodily injury; or not less than 24 hours if the events that cause the allegation do not involve abuse and did not result in serious injury.Facility incident report dated 5/24/26 documents that R1 and R2 got into a physical altercation after R2 became agitated at R1 over table seating in the dining room. R1 asked R2 to go to another table causing R2 to strike out at R1 and R1 picking up a chair and hitting R2 in the head causing R2 to go unconscious and receive 2 lacerations requiring medical intervention of sutures and staples at local hospital.On 6/24/26 at 1:30pm, V4 (Abuse Coordinator) confirmed that they have no documentation that state agency was notified of incident regarding allegation of resident-to-resident abuse on 5/24/26.