STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E888	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Health Care Willows	3520 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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 31283 Based on interview, observation and record review, the facility failed to protect residents from episodes of physical abuse occurring from 10/29/24 - 02/25/25 for seven (R1, R2, R4, R6, R7, R12 and R14) reviewed for abuse in the sample of 16. Findings include: The facility's 'Abuse Prevention Program Facility Policy' (updated 06/03/24) documents the following: 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. This same policy documents, The 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 documents, Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction on 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. 1. The facility's Incident Investigation Report (dated 10/29/24) documents the following: On 10/29/24 at 09:10 AM on H Hall, (R4) and (R1) were physically aggressive toward one another, hitting each other with closed fists. Residents were separated and counseled. No injuries were noted, (R4) was sent to the hospital for a psychiatric evaluation, and he was asking to go stating he wasn't feeling well. (R4) thought (R1) was going to hurt him so he hit (R1) first. Police involved in transport. This same investigation documents the following Action Plan: Care Plans updated and staff reminded to use hands-on assistance to redirect (R1) from peers rooms. (R4) reassured and reminded of alternate ways to handle situations. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Some	On 03/20/25 at 08:20 AM, V7 (Housekeeping) stated she witnessed the 10/29/24 altercation between R1 and R4. V7 stated, (R1) was following me around in the hall while I was cleaning. He always walks with me. I had pushed my (housekeeping) cart down the hall and had stopped it near (R4's) room. (R1) was standing in the hall in front of the doorway to (R4's) room. (R1) must have been in (R4's) view because I turned around for a second to grab something from my cart, and when I turned back around, (R4) was punching (R1). I called for help and (R1 and R4) were separated. R1's Minimum Data Set Assessment (dated 12/23/24), Section C, documents a Brief Interview of Mental Status assessment was not able to be conducted on R1 due to R1's impaired cognition (rarely/never understood). This same section also documents R1 has a short- and long-term memory problem. On 03/19/25 at 01:20 PM, R1 was wandering throughout the H hallway carrying an empty disposable plastic cup. R1 was dressed and groomed and was wearing nonskid socks. R1 appeared to be pleasantly confused and was cooperative at this time. R4's current medical record documents R4's diagnoses to include Anxiety Disorder, Delusional Disorder, and Disorientation. On 03/20/25 at 10:10 AM, R4 was lying in bed watching television. R4 was dressed and groomed, and a wheeled walker was nearby his bed within his reach. R4 denied ever having any altercations with anyone at the facility at this time and stated, I get along with everyone. On 03/20/25 at 08:40 AM, V1 (Administrator) stated that R1 and R4 did have a physical altercation on 10/29/24. V1 stated, (R1) was walking in the hallway and stepped in view of (R4's) doorway, and that's when (R4) approached him and started hitting him. V1 then stated R1 has a diagnosis of Dementia and frequently wanders throughout the facility. 2. The facility's Incident Investigation Report (dated 11/02/24) documents the following: On 11/02/24 at 12:50 AM on G Hall, (R1) and (R9) ran into one another causing both to fall to the floor. (R9) then hit (R1) in the forehead twice with a closed fist. Residents were separated and staff assessed for injuries- none noted. When nurse expressed to (R9) that the collision was an accident, (R9) apologized to (R1). This same investigation documents the following Action Plan: Staff reminded to redirect (R1) from other halls and intervene proactively. (R9's) care plan updated, and staff re-educated to intervene early if agitated- remind him to walk slowly toward corners of halls. R1's Progress Note (dated 11/02/24) documents the following: This resident was struck by another resident twice in the forehead after apparently tripping over him and taking both to the floor in the hallway of G-Hall. Full body assessment reveals no signs or symptoms of injury at this time. Resident placed on head protocol. (V6, Medical Director) and (V1, Administrator) notified and family notification pending. On 03/26/25 at 11:40 AM, V2 (Director of Nursing) stated she obtained a statement from V14 (Registered Nurse), who was the individual that responded to the 11/02/24 altercation between R1 and R9. V14's statement, which was documented by V2 and included in the facility's incident investigation, documents the following: (V2) Spoke with (V14)- he stated that (R1) was walking up the hall on G Hall, when he tripped and fell into (R9). (R9) then struck (R1) before (V14) could get to them. (R1) was struck in the head two times. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/25 at 09:00 AM, V1 (Administrator) confirmed R9 physically abused R1 on 11/02/24. V1 stated R9 is no longer residing at the facility because he refused to return to the facility after he was sent to a local hospital for evaluation following an incident that occurred on 11/18/24. 3. The facility's Incident Investigation Report (dated 11/10/24) documents the following: On 11/10/24 at 02:10 PM, in the main dining room, (R1) was pushing (R3's) wheelchair which upset him (R3). (R1) didn't understand (R3) wanted his chair back. (R3) hit (R1) in the face with a closed fist. Staff immediately separated and counseled the residents. This same investigation documents the following Action Plan: To prevent further abuse, (R3) was reminded to resolve conflict and that physical aggression can hurt himself and others. Staff reminded to redirect (R1) when noticing he has something of a peers. R1's Progress Note (dated 11/10/24 and timed 02:23 PM) documents, Resident was noted pushing a wheelchair around facility. Resident peer noticed that it was his wheelchair and wanted it back. An argument ensued and then this resident was hit several times in the face with a closed hand. R1's Progress Note (dated 11/10/24 and timed 09:45 PM) documents, Resident continues to wander and needs frequent redirection from entering peers' rooms. He becomes agitated with staff during redirection and starts pushing staff and attempts to strike staff. He refuses to go to bed at night and when he does go to bed, he only stays in the bed a short time and gets back up wandering again. He remains on H.P. (head protocol) with no s/s (signs and symptoms) neurological deficits. On 03/18/25 at 02:40 PM, V4 (Certified Nursing Assistant) stated the following in regards to the 11/10/24 incident involving R1 and R3: I remember (R1) was pushing a wheelchair and we had taken it away from him. He wandered and found another wheelchair. We had seen him pushing it and wondered whose wheelchair it was. Then I heard some commotion and (R3) was hitting (R1). I ran to break it up. (R3) had punched (R1) in the face at least three times before I had got to them. On 03/19/25 at 01:45 PM, R3 was seated on his wheeled walker against the back wall in the dining room. R3 was dressed, groomed, and was drinking a can of soda, and stated he purchased the soda from the vending machine. R3 stated he has had, Some disputes with a few (residents), in the past, but that ain't no big deal now. On 03/18/25 at 02:05 PM, V1 (Administrator) confirmed that (R3) physically abused (R1) on 11/10/24. 4. The facility's Incident Investigation Report (dated 11/12/24) documents the following: On 11/12/24 at 09:15 AM in the main dining room, (R5) went behind (R6's) wheelchair, grabbed the handlebars and tipped (R6's) chair backwards causing (R6) to fall. (R6) did not hit her head and she got up on her own. No injuries noted. Both residents were 'talking nonsense' per witnesses. Staff separated and monitored the two women. This same investigation documents the following Action Plan: To prevent further abuse, staff were educated to monitor (R5) and (R6) in common areas and redirect them from one another/other peers who may trigger them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Progress Note (dated 11/12/24) documents the following: Per witness resident (R16), (R5) was yelling/arguing with staff and female peer (R6). This resident (R5) noted to ambulate over to (R6), grabbed handles of wheelchair causing foot to base of wheelchair tilting wheelchair causing peer (R6) to fall from wheelchair. Both residents continue to argue as staff separated. Resident (R5) refuses to have vital signs done and full assessment. No apparent injuries noted. No complaints voiced. (V6, Medical Director), administrative staff notified. On 03/20/25 at 01:20 PM, R16 was sitting in his wheelchair near the window in the dining room. R16 was moving chess pieces around on a chess board, and recalls witnessing the 11/12/24 altercation that occurred between R5 and R6. R16 stated, They sit at different tables in the dining room, but they began arguing. (R5) got up and walked over to (R6). R16 then motioned his hands mimicking gripping an object, pulled his hands back toward his chest and explained as he mimicked R5 grabbing R6's wheelchair and tipping R6 wheelchair over backwards while R6 was sitting in it. R5's current medical record documents R5's diagnoses to include Major Depressive Disorder, Frontotemporal Neurocognitive Disorder, and Schizoaffective Disorder. On 03/20/25 at 02:25 PM, R5 was lying in bed with the hood of her shirt covering her head. R5 was mumbling incomprehensible phrases when greeted by this surveyor, and eventually stated, Get out. You need to get the hell out of here. R5 was not interviewed due to refusal. R6's current medical record documents R6's diagnoses to include Schizoaffective Disorder Bipolar Type, and Post Traumatic Stress Disorder. On 03/20/25 at 01:05 PM, R6 was propelling her wheelchair toward the vending machines in the dining room. When this surveyor approached and attempted to speak to R6, R6 began waving her left hand in the air above her, refused to speak with this surveyor and yelled the following nonsensical phrase: Nope! One went to heaven, and one went to hell, and I don't really care about any of it. On 03/20/25 at 12:40 PM, V1 (Administrator) confirmed R5 physically abused R6 on 11/12/24 when R5 deliberately tipped R6's wheelchair causing R6 to fall. 5. The facility's Incident Investigation Report (dated 11/13/24) documents the following: On 11/13/24 at 12:10 PM in the main dining room, (R8) was rolling up to a dining room table when (R7) started backing into her wheelchair. (R8) grabbed (R7's) arm and bit her. Redness was noted and ice was applied. Residents were separated to different tables and (R8) was counseled. (R8) has a diagnosis of Dementia and was confused as to what (R7) was doing. This same investigation documents the following Action Plan: Care Plan updated. To prevent further abuse, staff to intervene and assist (R8) proactively to address her needs (i.e. assist her to dining table). R7's Progress Note (dated 11/13/24) documents the following: (R7) noted arguing with peer (R8) over seating in dining room. Peer (R8) was pulling on (R7's) right arm and proceeded to pull her hair and bite her right forearm. Residents were separated and placed at different tables. Ice applied to (R7's) forearm. POA (Power of Attorney) contacted with no answer, left voicemail. Notified (V6, Medical Director) of incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V11's written statement (dated 11/13/24) documents, Observed residents in dining room having an altercation. (R8) was pulling on the right forearm of (R7) and proceeded to bite her right forearm. (R7) was observed trying to pull arm back from (R8). This RN (Registered Nurse) did a head-to-toe assessment on both residents, separated them at dining tables. RN (Registered Nurse) placed ice on (R7) and received order for PRN (as needed) ice pack to site. V11 was not able to be interviewed due to currently being out of state on vacation. On 03/24/25 at 09:25 AM, R7 was sitting in her wheelchair at a table in the dining room with her eyes closed. R7 was dressed and several food particles and crumbs were covering her lap. R7 was confused and could not recall the 11/13/24 incident when she was bitten by (R8). On 03/24/25 at 08:55 AM, V2 (Director of Nursing) stated R8 is currently not in the facility. V2 stated R8 was admitted to the local hospital, and was discharged from the facility because, She was sent to (sister facility) for physical therapy. She has since been sent back to the hospital due to pulling out her PICC (peripherally inserted central catheter) line. I believe she pulled it out on Friday. On 03/24/25 at 08:45 AM, V1 (Administrator) stated, If I recall, (R8) didn't like (R7) at her table. The two began arguing, and (R8) pulled (R7's) hair and bit her. 6. The facility's Incident Investigation Report (dated 11/18/24) documents the following: On 11/18/24 at 11:45 AM in the Main Dining Room, (R9) was walking through and hit (R1) in the face with a closed fist which caused him to fall to the ground. No initial injuries were noted. Incident was unprovoked. Non-emergency police were called and consulted with psychiatrist. (R1) went to the hospital for evaluation; (R9) went to (local hospital) for psychiatric evaluation. This same investigation documents the following Action Plan: (R1) returned with no injuries and was placed on 1:1 monitoring for 72 hours. (R9) refused to return to the facility from the hospital and was discharged . R1's Progress Note (dated 11/18/24) documents the following: (R1) was walking past (R9), (R9) turned and punched (R1) in face, staff immediately separated residents, full body assessment implemented, assisted into a chair, vitals obtained, (R1) complains of jaw pain, (V6, Medical Director) notified. (R1) sent to (local hospital) for evaluation and treatment, bed hold policy sent with resident, Power of Attorney notified, and writer received no answer, message left on voicemail. On 03/24/25 at 11:15 AM, V9 (Front Desk) stated he vaguely recalls the incident that occurred between R1 and R9 over four months ago on 11/18/24. V9 verified his witness statement included in R1 and R9's 11/18/24 Incident Investigation and stated the following, A lot of time has passed since then. I believe (R9) was sitting at a table, and when (R1) walked by, (R9) suddenly got and punched him in the face pretty hard. I started heading toward them when I saw (R9) stand up, and got there to catch (R1) and assist him to the floor. On 03/24/25 at 11:35 AM, V1 (Administrator) confirmed R9 physically abused R1 on 11/18/24. V1 stated, We sent (R1) to the hospital to get checked out because he was hit very hard in the face. The (local police) came and spoke with (R9) and gave him the option to go to the hospital, or they would be taking him to jail. (R9) agreed to go to the hospital and when he was ready to be discharged , he refused to return to the facility. (R9) was his own POA (Power of Attorney). We notified (V6, Medical Director) who gave the okay for (R9) not to return. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. The facility's Incident Investigation Report (dated 12/01/24) documents the following: On 12/01/24 at 02:02 PM in the main dining room, (R2) and (R1) were by the vending machines. (R2) was passing by (R1) and they began yelling at each other. (R1) hit the top of (R2's) head with a cup he was carrying. (R2) had a small laceration to his head. (V6, Medical Director), (V1, Administrator), responsible parties notified. (R2) was sent to the emergency room for evaluation. Returned with triple antibiotic ointment and a band-aid. On 03/18/25 at 02:20 PM, R15 stated he witnessed the incident between R1 and R2 on 12/01/24. R15 stated he recalls observing (R1) strike (R2) with a cup, but cannot recall much more, That was a long time ago. (R1) wanders around and does go into people's rooms. (R2) yells a lot. Due to R1's impaired cognition, he was unable to be interviewed about the 12/01/24 incident that occurred with R2. R2's Progress Note (dated 12/01/24 and timed 02:05 PM) documents the following: (R2) hit on the head with a cup by (R1) at the vending machine, (R2) sustained a little cut on the head that measures 0.5 centimeters by 0.2 centimeters with minimal bleeding. Area cleaned. Power of Attorney notified. (R2) placed on Head Protocol monitoring. Vitals as follows T (temperature) 97.6, (pulse) 78, R (respirations) 18, B/P (blood pressure) 140/81, SPO2 (pulse oximetry) 98. (V6, Medical Director) notified; order received to send (R2) to (local emergency department). (Emergency transport) here and resident taken to (local hospital). R2's Progress Note (dated 12/01/24 and timed 06:58 PM) documents the following: Resident returned from (local emergency department) with Triple Antibiotic Ointment and band-aid on the wound (abrasion), no new orders. Power of Attorney notified of his arrival. Will continue to monitor. On 03/19/25 at 01:35 PM, the door to R2's room was open approximately 6 inches. R2 was lying in a low bed with a fall mat in place and a bedside table positioned near the side of his bed. R2 was partially covered with a sheet, and was wearing a gown and an incontinence brief. An indwelling urinary catheter drainage bag was positioned inside of a dignity bag secured to the lower aspect of R2's bed. R2's call light was clipped on his bedding and within his reach. This surveyor knocked on R2's door and introduced herself. R2 became visibly upset and yelled, What are you doing? What do you want from me? R2 was not able to be interviewed regarding the 12/01/24 incident due to R2 becoming visibly upset upon greeting. On 03/18/25 at 02:30 PM, V1 (Administrator) confirmed that R1 physically abused R2 on 12/01/24 and stated, It happened. V1 then stated that staff were re-educated to remove objects from (R1) if he is carrying things in the facility, He has a tendency to take things of others that do not belong to him, and if staff see him carrying an item such as a cup, they should be intervening. 8. The facility's Incident Investigation Report (dated 12/05/24) documents the following: On 12/05/24 at 08:31 AM, (R2) was noted with bruising to his left eye. Upon investigation, (R10) admitted to hitting (R2) overnight. (R10) was receptive to counseling and requested a room move. (V6, Medical Director), (V1, Administrator) and responsible parties notified. Head protocol was initiated for (R2). This same investigation documents the following Action Plan: Care Plan updated for (R10) to seek out staff for help when bothered by peers/upset. Staff reminded to monitor (R2) if yelling at night to ensure safety and prevent abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/25 at 03:35 PM, V5 (Certified Nursing Assistant) stated the following regarding the 12/05/24 incident involving R2 and R10: I had worked second shift on 12/04/24, and had put (R2) to bed. I worked day shift the following morning of 12/05/25, and when I went into (R2's) room to get him up for the day, I noticed (R2) had a black eye that he did not have when I put him to bed the night before. I reported it to (V1, Administrator). (R2) didn't say what happened when I asked him about his black eye. I talked to (R10), who had a shared bathroom with (R2) at that time. At first, (R10) tried to tell me he didn't know what happened to (R2), but then (R10) told me he went through the bathroom into (R2's) room during the night and punched (R2) because (R2) wouldn't stop hollering. R2's Progress Note (dated 12/05/24) documents the following: Resident (R2) noted with bruising to left eye (purplish). (R2) unable to fully recall how bruising occurred. Vital signs: blood pressure 134/78, temperature 98.2, 78 pulse, 20 respirations. Perl (Pupils equal and reactive to light) and no signs or symptoms of neurological deficits and no complaints voiced. No other apparent injures noted. Head protocol initiated. All appropriate parties notified. R10's Minimum data Set Assessment (dated 01/28/25) documents a Brief Interview of Mental Status score of 14, indicating R10 is cognitively intact. On 03/24/25, R10 declined to be interviewed. On 03/24/25 at 03:30 PM, V1 (Administrator) stated R10 physically abused R2 sometime between the night of 12/04/24 and morning of 12/05/25 when R10 entered R2's room through the shared bathroom. V1 then stated R10 admitted to punching R2 because R2 was yelling for an extended period of time. 9. The facility's Incident Investigation Report (dated 12/20/24) documents, On 12/20/24 in the South Main Dining Room, (R11) hit (R12) with a closed fist to the mouth, causing her lip to bleed. (R12) was (repeatedly) running her wheelchair into the table at dinner which bothered (R11). Staff intervened and separated the residents. (R11) calmed with counseling. This same investigation documents the following Action Plan: Care Plans updated for staff to assist (R12) into a regular chair during meal service. Staff re-educated and (R11) received counseling about aggressive behaviors. R11's Progress Note (dated 12/20/24) documents the following: (R11) was reported by staff that he hit (R12). When asked, he answered, I hit her with my right fist. (R12) kept coming back to (R11's) table while he was still eating his meal. Plan of care to place (R12) on a chair while other residents are still eating. (R11) and other residents will be away from being bothered by (R12) while eating. On 03/25/25 at 10:30 AM, V1 stated V10 (Registered Nurse), who witnessed the 12/20/24 incident between R11 and R12, is currently out of the country on vacation and will not be able to be reached for interview. V10's written witness statement (dated 12/20/24), which was included in the 12/20/24 Incident Investigation, documents the following: This nurse was alerted that (R12) was hit by (R11). When asked, (R11) stated, 'Yes I hit her.' (R12) was removed from (R11's) table. Prior to that this nurse was getting the medication of other residents to pass. (R12) was done with her dinner and she kept doing it (banging into R12's dining table with her wheelchair) where staff were redirecting her. She was hit on her lower lip that caused it to bleed. (R12) was removed away from (R11) and applied ice pack on her lower lip. (V2, Director of Nursing), (V1, Administrator), and (V6, Medical Director) notified. (R12) was seated on the chair. Power of Attorney notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11's Minimum Data Set Assessment (dated 02/11/25) documents a Brief Interview of Mental Status score of 15, indicating R11 is cognitively intact. On 03/25/25 at 12:40 PM, R11 was lying in bed covered with a blanket. R11's glasses and his call light were within his reach on a nearby bedside table. An indwelling urinary catheter drainage bag was secured to the lower aspect of R11's bed. R11 stated he recalls the 12/20/24 incident that occurred with R12. R11 stated, (R12) was banging on the tables (with her wheelchair) and was trying to run into people. She almost knocked two people over. I finally had enough and told her to knock her sh#t off. R11 lifted his right hand and made a fist, and then explained he did strike R12 in the face on 12/20/24 and stated, I'd had enough so I popped her in the mouth. I haven't had any issues since then, but she still bumps the tables. She knows exactly what she's doing. The staff come and take care of it when she is doing it. R12's Minimum Data Set Assessment (dated 03/04/25) documents a Brief Interview of Mental Status score of 5, indicating severe cognitive impairment. On 03/25/25 at 01:00 PM, R12 was sitting in her wheelchair alone at a table in the dining room. The arms of R12's wheelchair were padded, and R12 had bilateral forearm sleeves in place. R12 had her head placed down on the table. R12 raised her head upon greeting. R12 was able to answer a few simple yes/no questions, but then began verbalizing nonsensical words. R12 then began repeatedly moving her wheelchair back and forth striking the dining table she was seated at. R12's Progress Note (dated 12/20/24) documents, At 06:25 PM while in the dining area, (R12) was hit by (R11) on her lower lip that caused it to bleed. She kept hitting (R11's) table while he was eating. She was redirected many times and kept away from resident's table. When asked, (R11) he answered, 'I hit her with my right fist.' They were separated right away by staff. Head to toe assessment done. (V6, Medical Director), (V2, Director of Nursing), (V1, Administrator) notified. R12's Power of Attorney was notified too. V6 advised ice pack PRN (as needed), Tylenol PRN and neuro (neurological) checks. Care plan was updated to place (R12) on a chair during mealtime. Placed her on a one on one after she was back in her wheelchair when all residents are done with their meals. On 03/25/25 at 10:25 AM, V1 (Administrator) verified R11 struck R12 in the face on 12/20/24. V1 stated, (R12) has a history of repeatedly running her wheelchair into things. On 12/20/24, she was repeatedly running her wheelchair into the dining table where they (R11 and R12) were sitting. This upset (R11), and he hit (R12). We now transfer (R12) into a regular chair for meals. 10. The facility's Incident Investigation Report (dated 02/13/25) documents the following: On 02/13/25 at 11:00 AM in the North Dining Room, (R14) was yelling for a staff member as the staff member was exiting the bathroom. Before the staff member could get to (R14), (R13) approached (R14) and hit him in the face two times with a closed fist. Staff immediately intervened and separated the pair. Counseling provided. No injuries noted. This same investigation documents the following Action Plan: (R13) received counseling and care plan updated for (R13) to have patience with others' behaviors and allow staff to intervene without becoming aggressive. (R14) was reminded that yelling can bother peers and cause conflict. (continued on next page)

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	14E888	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Health Care Willows	3520 North Rochelle Peoria, IL 61604

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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 - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/25 at 03:00 PM, V12 (Certified Nursing Assistant) stated she witnessed the 02/13/25 incident between R13 and R14. V12 verified her written statement included with the facility's Incident Investigation, and then stated the following: I ran to use the bathroom real quick. (R14) was yelling my name, which he frequently does when he sees me. One of his behaviors is yelling out. When I exited the bathroom, I could still hear (R14) yelling my name. As I was approaching, I saw (R13) propelling his wheelchair toward (R14), and before I had reached them, (R13) punched (R14) twice in the face pretty hard with a closed fist. (R13 and R14) were immediately separated. R13's Progress Notes (dated 02/13/25) documents the following: CNA (Certified Nursing Assistant) came to this nurse stating that (R13) and another resident (R14) got into a physical altercation. CNA stated that (R13) rolled up in his wheelchair on peer resident (R14) and proceeded to hit peer resident in his jaw two times with a closed fist. (R13) stated he hit (R14) in the face because he was yelling. Residents were moved to different parts of the dining room. Residents were reeducated on knowing how to avoid conflict with peer residents that share the same living environment. On 03/26/25 at 09:55 AM, R13 was sitting in a high-back wheelchair on the smoking patio smoking a cigarette. R13 was wearing a coat and stocking hat, and a full mechanical lift sling was in place underneath of him. R13 stated he has lived at the facility for [AGE] years, and gets along with 'most' residents. R13 stated he punched R14 in the face on 02/13/25 and added, (R14) is one I don't like. He's a pedophile, and I came unglued that day. R14's Minimum Data Set Assessment (dated 03/10/25) documents a Brief Interview of Mental Status score of 15, indicating R14 is cognitively intact. R14's Progress Note (dated 02/13/25) documents the following: CNA (Certified Nursing Assistant) came to this nurse stating that (R14) and another resident (R13) got into a physical altercation. CNA stated that peer resident (R13) rolled up in his wheelchair on (R14) and proceeded to hit (R14) in his jaw two times with a closed fist. Peer resident (R13) stated he hit (R14) in the face because (R14) was yelling. Residents were moved to different parts of the dining room. Residents were reeducated on knowing how to avoid conflict with peer residents that share the same living environment. On 03/26/25 at 09:40 AM, R14 was lying in bed watching television. R14's call light was within his reach, and R14 was sparsely covered with a blanket. R14 stated he recalls the 02/13/25 incident that occurred with R13 and stated, (R13) hit me in the jaw. Sometimes he be acting crazy. I was ok, and we haven't had problems since. On 03/25/25 at 03:15 PM, V1 (Administrator) confirmed R13 struck R14 in the face with a closed fist on 02/13/25. V1 stated, (R14) is one that yells out, and it can upset his peers. 11. The facility's Incident Investigation Report (dated 02/25/25) documents the following: On 02/25/25 at 06:55 PM in the dining room after dinner, (R5) grabbed the wheelchair handle bars behind (R6) and pulled her to the floor. Staff immediately intervened and separated the women. (R5) said that (R6) said something to her. Residents were redirected without further incident. (R6) sustained no injuries. This same report documents the following Action Plan: Residents were redirected to separate areas of the building and CNAs (Certified Nursing Assistants) on halls were instructed to monitor/keep them separate. No further issues occurred. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's Progress Note (dated 02/25/25) documents the following: This resident (R5) was talked to negatively and confronted by a peer resident (R6) which caused her (R5) to tilt peer's wheelchair backwards, leaving it propped on the handles. Resident (R5) assisted to room for de-escalation. (V6, Medical Director) notified, guardian notified. No further action required. R6's Progress Note (dated 02/25/25) documents the following: Resident (R6) was talking negatively and being confrontational to another resident peer (R5). Resident (R5) then proceeded to tilt (R6's) wheelchair backwards, causing her chair to land on the handles propping the resident (in her wheelchair) upwards. (R6) never hit the floor no apparent injuries noted, full body assessment done. (V6, Medical Director) notified, guardian notified, no other concerns at this time. On 02/25/25 at 03:30 PM, V13 (Certified Nursing Assistant) stated she witnessed the 02/25/25 altercation that occurred between (R5) and (R6). V13 stated, (R5) got up from the table quickly, approached (R6), grabbed the handlebars to (R6's) wheelchair and pulled it backwards until the handlebars landed on the ground. (V6) did not hit her head. I believe (R5) was upset because of something (R6) said to her. On 03/27/25 at 09:15 AM, V1 (Administrator) verified R5 became upset and proceeded to tip R6's wheelchair backwards causing R6 to fall after R6 had verbalized something that upset R5.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31283 Based on interview, observation and record review, the facility failed to implement behavioral interventions to prevent episodes of physical abuse for seven residents (R1, R4, R5, R6, R9, R11 and R12) reviewed for abuse in the sample of 16. Findings include: The facility's Abuse Prevention Program Facility Procedures policy (updated 06/03/24) documents the following: As part of the resident social history evaluation and Minimum Data Set assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or misappropriation of resident property, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis. The facility's Behavior Monitoring policy (updated 06/05/24) documents the following: At any time the IDT (Interdisciplinary Team) may initiate resident checks for increased monitoring, either on an hourly, 15 minute or one-to one staff basis. This same policy documents, 'IDT will review residents on an increased monitoring and may discontinue checks at any time if they determine the monitoring is no longer necessary. This policy also documents, If a resident displays an increase in behavioral disturbances, his/her treatment plan will be reviewed and modified by the interdisciplinary team as needed. Any identified resident may be referred to the Psychiatrist for a medication efficacy review and adjustment as indicated. 1. R4's medical record documents R4's diagnoses to include: Anxiety Disorder, Delusional Disorder, and Disorientation. R4's Progress Note (dated 10/28/24) documents the following: (R4) noted in dining room. Approached female peer grabbed/placed hands to jawline of female peer in attempt to kiss peer then bit her on the left cheek. Both residents immediately separated. No injuries noted. Resident counseled regarding behavior. Family, administration and (V6, Medical Director) notified. R4's Progress Note (dated 10/28/24) documents the following: (R4) noted with increased mood swings with behavioral deficits. Attempted to hit a male peer with no provocation. (R4) counseled and begin to further become irate, expressing delusional comments related to events that are happening now. (R4) counseled by male staff member (R4) then expressed feeling of needing more medication. (Local mental health provider) here for weekly rounds and recommended to evaluate medication therapy for increased behaviors. R4's Progress Note (dated 10/28/24) documents the following: Assessed by (local mental health provider) today. New orders received to increase Seroquel (antipsychotic) to 100 milligrams by mouth every bedtime and start Seroquel 75 milligrams by mouth every morning, Depakote level in AM (morning). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Progress Note (dated 10/28/24) documents the following: (R4) was very agitated and was in a verbal altercation with a peer during breakfast approximately 08:45 AM this morning. (R4) was asked to calm down, (R4) abruptly left the dining room for approximately 10 minutes and returned still angry with the peer. R4's Progress Note (dated 10/29/24) documents the following: Summoned to hall per staff. (R4) noted in doorway of room having a physical altercation with another male resident (R1). Both parties immediately separated. (R4) refused vital signs and full body assessment. Per observation no physical injuries noted. No complaints voiced. (R4) counseled per psychiatric social department. Family, administrative staff and (V6, Medical Director) notified. The facility's Incident Investigation Report (dated 10/29/24) documents the following: On 10/29/24 at 09:10 AM on H Hall, (R4) and (R1) were physically aggressive toward one another, hitting each other with closed fists. Residents were separated and counseled. No injuries were noted, (R4) was sent to the hospital for a psychiatric evaluation, and he was asking to go stating he wasn't feeling well. (R4) thought (R1) was going to hurt him so he hit (R1) first. Police involved in transport. This same investigation documents the following Action Plan: Care Plans updated and staff reminded to use hands-on assistance to redirect (R1) from peer's rooms. (R4) reassured and reminded of alternate ways to handle situations. R4's current Care Plan documents the following focus: (R4) has a criminal background with charges of Aggravated Battery in 1994, Carry and Possess Firearm & Battery and Assault in 1985. (R4) may become physically aggressive with peers at times. This same care plan documents the following interventions were in place at the time of R4's altercation with R1 on 10/29/24: Encourage (R4) to participate in activities to increase positive peer interaction; Explain to (R4) the legal consequences of any new incidents of his previous offense; If staff notice (R4) in close proximity to a peer, staff to redirect and reassure his actions will not turn to physical aggression; Refer (R4) for Psychiatric consult as needed for increased agitation or aggression; Staff to intervene proactively when (R4) is becoming agitated with staff or peers to assist, reassure and redirect. R1's Current Care Plan documents the following focus: (R1) wanders throughout the facility, up and down halls and in common areas. (R1) may enter one of his peers' rooms without knowing due to Alzheimer's Disease. (R1) may pick up/mess with peers' belongings. This same care plan documents the following intervention was in place at the time of R1 and R4's 10/29/24 altercation: Staff will assist (R1) in maintaining appropriate boundaries between himself and peers/redirect from peers' rooms. On 03/20/25 at 08:40 AM, V1 (Administrator) stated that R1 and R4 had a physical altercation on 10/29/24. V1 confirmed R4 was never placed on 15-minute checks and stated, We can implement 15-minute checks or 1:1 monitoring with an increase in behaviors, and (R4) was having an increase in behaviors at that time. Looking back, we probably should have put him on 15-minute checks before the altercation with (R1) occurred, and staff should have redirected (R1) away from the doorway of (R4's) room. 2. R5's current medical record documents R5's diagnoses to include: Major Depressive Disorder, Frontotemporal Neurocognitive Disorder, and Schizoaffective Disorder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Incident Investigation Report (dated 11/12/24) documents the following: On 11/12/24 at 09:15 AM in the main dining room, (R5) went behind (R6's) wheelchair, grabbed the handlebars and tipped (R6's) chair backwards causing (R6) to fall. (R6) did not hit her head and she got up on her own. No injuries noted. Both residents were 'talking nonsense' per witnesses. Staff separated and monitored the two women. This same investigation documents the following Action Plan: To prevent further abuse, staff were educated to monitor (R5) and (R6) in common areas and redirect them from one another/other peers who may trigger them. R5's current care plan documents the following focus: (R5) has daily behaviors of yelling out in her room and common areas due to hallucinations related to Schizoaffective Disorder. (R5) may be physically aggressive at times. She can be resistive to redirection and refuses any medical intervention. This same care plan documents the following intervention was implemented on 11/12/24: Staff to monitor (R5) in common areas and redirect her from other residents whose behaviors may trigger her. R6's current Care Plan documents the following: (R6) experiences auditory hallucinations and has delusions that she is dead. (R6's) delusional comments may negatively impact others at times. This same care plan documents the following intervention was implemented on 11/12/24: Staff to monitor (R6) in common areas and redirect her from other residents whose behaviors may be triggered. The facility's Incident Investigation Report (dated 02/25/25) documents the following: On 02/25/25 at 06:55 PM in the Dining Room after dinner, (R5) grabbed the wheelchair handlebars behind (R6) and pulled her to the floor. Staff immediately intervened and separated the women. (R5) said that (R6) said something to her. Residents were redirected without further incident. (R6) sustained no injuries. This same report documents the following Action Plan: Residents were redirected to separate areas of the building and CNAs (Certified Nursing Assistants) on halls were instructed to monitor/keep them separate. No further issues occurred. On 03/27/25 at 09:15 AM, V1 (Administrator) stated that on 02/25/25, R5 became upset and proceeded to tip R6's wheelchair backwards causing R6 to fall after R6 had verbalized something that upset R5. V1 stated this is the second occurrence in which R5 has grabbed and tipped R6's wheelchair over in the dining room, and staff should be monitoring R5 and R6 closely when they are within close proximity of each other. 3. The facility's Incident Investigation Report (dated 11/02/24) documents the following: On 11/02/24 at 12:50 AM on G Hall, (R1) and (R9) ran into one another causing both to fall to the floor. (R9) then hit (R1) in the forehead twice with a closed fist. Residents were separated and staff assessed for injuries- none noted. When nurse expressed to (R9) that the collision was an accident, (R9) apologized to (R1). This same investigation documents the following Action Plan: Staff reminded to redirect (R1) from other halls and intervene proactively. (R9's) care plan updated and staff re-educated to intervene early if agitated- remind him to walk slowly toward corners of halls. R1's Current Care Plan documents the following focus: (R1) wanders throughout the facility, up and down halls and in common areas. (R1) may enter one of his peers' rooms without knowing due to Alzheimer's Disease. (R1) may pick up/mess with peers' belongings. This same care plan documents the following intervention is currently in place: Staff to redirect (R1) from other halls and escort him to his room as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R9's most recent Care Plan documents the following focus initiated on 06/21/23: (R9) has a diagnosis of Paranoid Schizophrenia and Major Depressive Disorder. (R9) has been observed to make delusional statements and respond to auditory hallucinations. He may be physically aggressive related to his paranoia. This same care plan documents the following interventions were in place at the time of R9's altercation with R1 on 11/02/24: (R9) has specific peers who trigger his delusional thought process. Staff to proactively intervene to prevent altercations; Encourage (R9) to vent his feelings when he feels uncertain or upset for any reason at any given moment; Observe (R9) to find what may trigger hallucinations/delusions to eliminate behaviors; Remind (R9) of potential legal consequences of physical aggression toward peers; Remind (R9) to get staff if peers are in his space/bothering him; Staff to intervene proactively if noticing (R9) is agitated by peers that may trigger aggression; Staff to provide 1:1 counseling to reassure paranoid thoughts. On 03/26/25 at 09:00 AM, V1 (Administrator) confirmed R9 physically stuck R1 in the face on 11/02/24. V1 stated at the time the 11/02/24 incident occurred, R1 was ambulating in a hall in which he did not reside, and staff should have redirected R1 out of the hall he was wandering in at that time. 4. The facility's Incident Investigation Report (dated 12/20/24) documents, On 12/20/24 in the South main Dining Room, (R11) hit (R12) with a closed fist to the mouth, causing her lip to bleed. (R12) was (repeatedly) running her wheelchair into the table at dinner which bothered (R11). Staff intervened and separated the residents. (R11) calmed with counseling. This same investigation documents the following Action Plan: Care Plans updated for staff to assist (R12) into a regular chair during meal service. Staff re-educated and (R11) received counseling about aggressive behaviors. R11's current Care Plan documents the following focus: (R11) has potential to be physically aggressive and may be easily agitated by peers. This same care plan documents the following intervention was in place at the time of the 12/20/24 incident that occurred between R11 and R12: When the resident becomes agitated: Intervene before agitation escalates, Guide away from source of distress, Engage calmly in conversation, If response is aggressive staff to walk calmly away and approach later. On 03/25/25 at 12:40 PM, R11 was lying in bed covered with a blanket. R11's glasses and his call light were within his reach on a nearby bedside table. An indwelling urinary catheter drainage bag was secured to the lower aspect of R11's bed. R11 stated he recalls the 12/20/24 incident that occurred with R12. R11 stated, (R12) was banging on the tables and was trying to run into people. She almost knocked two people over. I finally had enough and told her to knock her sh#t off. R11 lifted his right hand and made a fist, and then explained he did strike R12 in the face on 12/20/24 and stated, I'd had enough so I popped her in the mouth. I haven't had any issues since then, but she still bumps the tables. She knows exactly what she's doing. The staff come and take care of it when she is doing it. R12's current Care Plan documents the following focus: (R12) displays attention seeking behavior by running her wheelchair into staff, peers, and objects. This same care plan documents the following intervention in place (initiated 06/25/23): Staff will redirect (R12) when she is displaying behaviors of running her wheelchair into doors, walls, staff and her peers. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/25 at 01:00 PM, R12 was sitting alone in her wheelchair at a table in the dining room. The arms of R12's wheelchair were padded, and R12 had bilateral forearm sleeves in place. R12 had her head placed down on the table. R12 raised her head upon greeting. R12 was able to answer a few simple yes/no questions, but then began verbalizing nonsensical words and began repeatedly moving her wheelchair back and forth striking the dining table she was seated at. On 03/25/25 at 10:25 AM, V1 (Administrator) verified R11 struck R12 in the face on 12/20/24. V1 stated, (R12) has a history of repeatedly running her wheelchair into things. On 12/20/24, she was repeatedly running her wheelchair into the dining table where they (R11 and R12) were sitting. This upset (R11), and he hit (R12). We now transfer (R12) into a regular chair for meals. Staff was re-educated to intervene when (R11) becomes agitated with a peer, and to redirect (R12) when she is displaying behaviors of running her wheelchair into objects that disrupt her peers.