STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007298	A. BUILDING: ______ B. WING ______	C 07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE PINES	3614 NORTH ROCHELLE PEORIA, IL 61604

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S 000	Initial Comments Facility Reported Incident Investigation of 7/5/22 /IL149013	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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care needs of the resident.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirments were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect a resident (R1) from physical and verbal abuse by a staff member for one of three abuse allegations reviewed. This failure resulted in (R1) being verbally abused by (V4) and forcefully pushed to the ground. Then, (R1) was struck in the right side of his face with an open hand and struck on the left side of his face with a closed fist causing (R1) to fall to the floor. (R1) was sent to the ER (Emergency Room) where he was diagnosed with skin tear of left upper arm, closed head injury, and strain of lumbar region. This had the potential to affect all 95 residents residing in the facility.

Findings include:

The facility's Abuse Prevention Program, no date available, documents, "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 facility is committed to protecting our residents from abuse by anyone including, but not limited

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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."

The facility Security Monitor Job Description, no date available, documents, "A Security Monitor is to provide a safe and secure environment for the residents of this facility. All security staff shall present themselves in a professional manner at all times. Your duties as Security Monitor at Sharon Healthcare Pines are as follows: You are hired in a security position, and you shall carry yourself as a security person at all times when working."

On 7/18/22 at 12:07 p.m., (R1) was standing in the dining room. (R1) stated, "That worker (V4/Security) at the front desk hit me and shoved me down for no reason. I was just trying to talk to someone about going to my wife's house, and he pushed me down." (R1) went on to say, "Look at my arm (pointing at several irregular shaped dark brown scab areas to his left elbow) (V4) messed it up." While speaking with (R1), he pointed to these areas.

On 7/19/22 at 2:00 p.m., video surveillance of 7/5/22 was reviewed with (V2/Director of Nursing). At 8:39 p.m., (V4) walking down hallway towards the dining room. (V5/Certified Nurse Aide/CNA) was standing with (R1). (R1) was agitated and (V5) was attempting to redirect him. (V4) walked up to (V5) and (R1). (V4) was behind (V5) and (R1) was in front of (V5). (V5) suddenly jumped out of the way. (R1) attempted to swing at (V4) with his right arm. (V4) ducked back, but at the same time swung his left arm striking (R1) on the left side of his face with an open hand. (R1) attempted to hit (V4) again. (V4) was holding a

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S9999	Continued From page 3 key with a PVC (polyvinyl chloride) pipe attached to it in his right hand. When (R1) attempted to hit (V4) again, (V4) hit (R1) with a closed fist that was also holding the PVC pipe on the left side of (R1's) face knocking (R1) to the ground. As soon as (R1) hit the floor, (V4) looked at (R1) on the ground and walked away. (V5) began assisting (R1). At 8:43 p.m., (R1) walked up to the security desk, picked up a box of surgical masks and threw them at (V4) who was sitting behind the desk. (V4) picked up the box and threw it back at (R1) hitting him in the left shoulder. At 8:49 p.m., (V6 /Social Services) showed up to the facility and asked (V4) to leave. (V4) exited the facility at 8:51 p.m. At 8:54 p.m., the ambulance arrived to the facility to transport (R1) to the emergency room. On 7/26/22 at 10:10 a.m., video surveillance was reviewed with (V5) and (V13/Social Services/Human Resources): The camera angles were changed from previous viewing to now point at the nurses' desk. At 8:37 p.m., (R1) was standing at the nurse's station, on the nurses' station phone behind the desk. (V4) walked up to the nurses' desk and removed the phone from (R1's) hand. (V4) got in between (R1) and the desk. (R1) swung at (V4) with his right closed fist. (V4) raised his right arm and forcefully pushed (R1) in the chest using the back side of (V4's) forearm. (R1) fell to floor. (V4) did not assist, nor did he summons any staff. (V4) walked behind the desk while (R1) got himself up off of the floor. (V4) was on the phone while (R1) stood there watching (V4). At this point of viewing, (V5) and (V13) stated that no one was aware (V4) shoved (R1) down while standing at the nurses' station. (V13) stated, "(R1) normally isn't this violent. So, I've always felt like something must have happened to really make him mad at (V4). Well,	S9999		

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S9999	Continued From page 4 he was obviously mad because (V4) shoved him down at the nurses' desk before the other incident even happened." Continuing with the video surveillance: At 8:38 p.m., (V4) left the desk. (V5) walked up to the desk, and (R4) approached (V5) talking to (V5) over excitedly. (V5) stated, "(R4) told me someone had pushed (R1) down, but that was it." (V4) entered the men's restroom with a key attached to an approximately 12 inch long by 1 inch wide PVC pipe attached to it. Once (V4) exited the bathroom, he walked up the hallway towards (R1) and (V5). On 7/20/22 at 10:45 a.m., (V5/CNA) stated, "I'm not sure what led to the argument between (R1) and (V4/Security). When I came back into the building all I heard was (R1) yelling. (V4) was walking towards me and I asked him what was going on. (V4) told me that (R1) was upset because (V4) told him that he couldn't use the nurses' station phone. (R1) was wanting to get to (V4) at the front desk. I was trying to defuse this situation and I was pushed out of the way by (R1). (R1) yelled at (V4) that he was going to beat the s*** out of him. (R1) charged (V4) and (V4) hit him a few times. (V4) slapped (R1) in the face twice and caused (R1) to hit the floor. After (V4) hit him, when (V4 walked away he called (R1) a 'b***h a*s mother f****r'. I was trying to defuse the situation as much as I could. (R1) tried to get up to (V4) two different times at the front desk. I stayed with him the whole time. The first time we were up there, (R1) threw a bottle of hand sanitizer at (V4) behind the desk. (R1) said, 'That mother f****r smacked me.' (V4) responded back to him, 'If you're trying to come back here, I'm going to whip your a*s.' I got (R1) to walk back up the hall, but he went right back to the desk. (R1) grabbed a box of surgical masks and threw them	S9999		

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at (V4). (V4) then threw the box back at (R1) hitting him in the shoulder. (V4) said, 'Let him back here."

The facility's 24-hour Abuse Investigation Report, dated 7/6/22, documents, "7/5/22 at 8:40 p.m., (R1) in dining area, had altercation and fell causing injury. Skin tear to elbow."

The facility's Final Abuse Investigation Report, dated 7/5/22, documents, "(R1) was in the front lobby on 7/5/22 at 8:40 p.m. Got involved in a verbal altercation escalated to physical confrontation resulting in resident falling with resulting in injury to his elbow. (R1) was agitated in the front lobby was yelling at (V4/Security). (R1) continued to cuss and yell at staff. (R1) tried to hit (V4) and (V4) hit him back. (R1) tried to hit (V4) again and (V4) again hit (R1) causing him to fall. An abusive incident occurred resulting in (V4) being terminated."

Facility Information report, no date available but signed by (V6 /Social Services), documents, "Watched incident (security camera footage) from 7/5/22 on 7/6/22. (R1) was seen approaching my staff (V4) in an agitated manner. (R1) attempted to hit (V4) twice but (V4) hit him back both times caused (R1) to fall."

Facility Information report dated 7/6/22 and signed by (V3/Assistant Director of Nursing), documents, "I observed video surveillance of an incident that occurred between a staff member (V4) and a resident (R1) that took place on 7/5/22 during the evening hours. While watching the video footage, I observed a female staff member (V5) attempting to redirect (R1) who was ambulating toward the front exit. I then observed another staff member (V4) approach (R1) and the

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S9999	Continued From page 6 other staff member. (V4) stood between the female staff member (V5) and (R1) in an attempt to resolve the situation. I then observed (R1) then swing his arm/fist at (V4's) head however, (V4) ducked and no contact was made. (V4) then swung at (R1) making contact causing (R1) to fall to the floor. (V4) then turned and walked away while the other staff member along with several others tended to (R1)." Facility Information report dated 7/5/22 and signed by (V5/ CNA), documents, "I came in from outside to (V4) and (R1) going back and forth about (R1) answering the nurse phone. (V4/Security) began to call (R1) names and (R1) started following (V4) calling him names back. (V4) then turned around and started to approach (R1). (V4) then got into (R1's) face and (R1) swung at (V4). (V4) then hit (R1). (R1) swung again and missed (V4) then hit (R1) again in the face causing (R1) to fall to the ground and start to bleed." Facility Information report dated 7/6/22 and signed by (V6/Social Services), documents, "There was a physical altercation between my staff/front desk person (V4) and the resident (R1) resulting in a fall for the resident with an injury. (V4) was suspended pending abuse investigation. (R1) told me, 'I didn't fall that black man up front pushed me down." (R1's) Emergency Room Progress notes, dated 7/5/22, document, "(R1) presents to emergency department today after ground level-fall. He notes that he was shoved, and he fell backwards. He is complaining of head and neck pain as well as some lower right lumbar pain. He also notes that he has a skin tear to his left elbow."	S9999		

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(R1's) Emergency Room After Visit Summary, dated 7/5/22, documents, "Reason for visit: Neck pain. Diagnoses: Fall from ground level; Skin tear of left upper arm; closed head injury; Strain of lumbar region."

On 7/20/22 at 12:10 p.m., (V7/Registered Nurse) stated, "I didn't witness the actual incident, but I helped with the laceration on (R1's) arm up. I could hear (V4) yelling, but I can't recall what was said. The other nurse and myself took care of (R1). The jagged laceration was on his left elbow. It was about 2 inches long and deep enough that it needed something to close it. We couldn't get it to stop bleeding, he was complaining of back pain, and since he had been hit in the head, we made sure and sent him to the ER. We wanted to make sure there was no fractures or any other injuries and get that wound closed up. (R1) has mental health issues and likes to instigate things, but (V4) should know what population he works in. You can't react to that. (V4) needed to just walk away."

On 7/26/22 at 1:10 p.m., (R5) stated, "(R1) and (V4) got into a verbal argument in the dining room. It seemed like (R1) wanted to fight (V4). I heard them yelling back and forth, but I don't know what they said. I didn't see (V4) hit (R1). All I saw was (R1) falling to the ground. (R1) told me that (V4) had pushed him down."

On 7/26/22 at 1:40 p.m., (R4) stated, "There was arguing between (R1 & V4). There was a lot of cuss words going on back and forth between the two of them. It seemed like (V4) got frustrated, snapped, and pushed (R1) down. I told (V4) that (R1) got shoved down onto the floor, but I didn't tell her who it was."

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S9999	Continued From page 8 On 7/20/22 at 2:30 p.m. (V2/Director of Nursing) stated, "(V4) physically abused (R1). He hit him not once but twice. It makes me sick. He was suspended immediately, and then terminated the following day for abuse." V4's Employee Report, dated 7/6/22, documents that (V4) was terminated for abuse. The facility's Census Number, dated 7/26/22, documents that 95 residents reside in the facility. (A)	S9999		