STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED  C  08/15/2023	
0052		IL6007298		B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET	DORESS, CITY,	STATE, ZIP CODE			
SHAROI	N HEALTH CARE PINE	ES 3614 NO	RTH ROCHE , IL 61604				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCENCY)	II (C) 05	COMP DA	
S 000	Initial Comments		S 000				
7. 10 10 10 10 10 10 10 10 10 10 10 10 10	Facility Reported In 08/01/23/IL162918	cident Investigation of		1.2		of the paragraphic foliability intermemperature for the	
S9999	Final Observations	\$ P	S9999	e 	2	Ye management on A p a delical frame	
	Statement of Licens	sure Violations:			0.57	And the state of t	
	300.610a) 300.1210b	70 W	8	# P P P P P P P P P P P P P P P P P P P		And Apply ages of the Apply ag	
47 S	300.3210t) Section 300.610 Re	roldomi Onco Pottoto				Wilder op Hillian of Africa American	
the statement of the st	procedures governin facility. The written p be formulated by a F Committee consistin administrator, the ad medical advisory cor	shall have written policies and all services provided by the policies and procedures shall Resident Care Policy g of at least the lylsory physician or the mmittee, and representatives services in the facility. The		X =	The second secon		
t	policies shall comply The written policies s he facility and shall t	with the Act and this Part.  shall be followed in operating be reviewed at least annually becomented by written, signed	1 33 13 64		Administration with the appropriate to the stage of equipment of of equip	500	
8	Section 300.1210 Ge Nursing and Persona	eneral Requirements for ll Care	92	1	m.i.a.i.i.i.j.j.j.j.j.j.j.j.j.j.j.j.j.j.j		
c p w e pi	are and services to a racticable physical, a rell-being of the resic ach resident's comp lan. Adequate and p are and personal car	nall provide the necessary attain or maintain the highest mental, and psychological dent, in accordance with rehensive resident care roperly supervised nursing re shall be provided to each otal nursing and personal		Attachment A Statement of Licensure Viol	ations		

TCHJ11

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6007298 B. WING 08/15/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3614 NORTH ROCHELLE SHARON HEALTH CARE PINES **PEORIA, IL 61604** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 1 \$9999 care needs of the resident. Section 300.3210 General The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident (R2), for one of three residents (R1), reviewed for abuse, in a sample of five. Due to the physical abuse R1 experienced an abrasion to R (right) hand knuckles, skin tear to bridge of nose and laceration to L (Left) cheek. FINDINGS INCLUDE: The facility policy, Abuse Prevention and Reporting, dated (reviewed 7/11/23) directs staff. "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. 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." R1's Nursing Progress Notes, dated 8/1/2023 at 6:30 P.M. document, \*(R1) got in a physical altercation with peer (R2) at the smoking patio. Abrasion to R (right) hand knuckles, skin tear to bridge of nose and laceration to L (Left) cheek.

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Illinois E	Department of Public				FO	RM APPROVE
STATEME! AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		ATE SURVEY
			A. BUILDING:		C	OMPLETED
17.		IL6007298	B. WING			C
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	TATE, ZIP CODE		8/15/2023
SHARON	I HEALTH CARE PIN		TH ROCHEL			
		PEORIA,		=		
PREFIX (EACH DEFICIENC		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	age 2	S9999			
3.1	Physician called, vo	picemail box not set up. Talked				
	to (R1's) POA (Pow	ver of Attorney), Area				
	an ice nack given	ple Antibiotic Ointment) applied (R1) started on neuro				
1	(neurological) chec	ks. (Local) Police alerted, Ofc				
	(Officer) #1283 ass	essed both residents and				
	to residents being u	uld not perform an arrest due unfit for commitment. Resident				
- 1	noted to be going b	ack towards the smoking patio				
	at around 7:34 P.M.		la S			
	The facility Final Ab	use Investigation Report				
- 13	dated 8/6/23 and sig	gned by V3/Abuse				
	Coordinator docume	ents, "On 8/1/23 at				į.
	approximately 6:30 (R1) and (R2) were	P.M., in (facility) patio area, in a verbal altercation which				
13	escalated into a phy	sical altercation, (R2)				
1	sustained scratches	. (R1) using racial sturs in				
	regaru to (RZ), (RZ) Der several witness	continued provoking of (R1) es. (R2) then struck (R1)	1			1
	several times in the	face and pulled (R1) from the				1
	chair to the ground.	Staff immediately intervened				60
18	delusional thought n	ents. (R1) and (R2) having rocesses secondary to TBI	9.			
11.0	Traumatic Brain Inju	ury). (R1) displays impaired				
C	fecision making and ailed (due to outstar	poor impulse control. (R2)				
						4 12
C	On 8/14/23 at 11:30	A.M., V3/Abuse Coordinator				
S	tated, "(R2) has a h	istory of verbal peers and staff. I interviewed				1
a	ill residents on the p	patio at the time of the				1.8
ir	ncident (8/1/23) and	all state (R1) instigated the				1
V	erbal altercation, bu	t (R2) became physically				
a	nd hit (R1). Local P	led (R1) from his wheelchair				
in	ivestigated, and arro	ested (R2) and transported				
hi	im to jail"	,				
0	n 8/15/23 at 10:00	A.M. V1/Administrator stated				l.

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Illinois Department of Publi STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DAT	(X3) DATE SURVEY COMPLETED		
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SHARON	HEALTH CARE PIN		TH ROCHEL				
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\$9999	weren't going to an once they ran R2's	police came to the facility after en R1 and R2 on 8/1/23, they rest either resident. However, name through their database, ue to an outstanding warrant	S9999		,		
	(B)						
					The state of the s		
			Application of the		<i>3</i>		
					And in Application of the Applic		

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