STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032763	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint Survey 2526873/2570489	S0000		08/12/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not	S9999		08/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032763	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 1 subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on record review and interview, the facility failed to protect a resident from physical abuse for two of four (R1 and R3) residents reviewed for abuse in a sample of four. This failure resulted in R1 sustaining a complex fracture of the left hip requiring surgical intervention. Findings include: The facility's Abuse Prevention Program, reviewed 7/21/25, documents that abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This form also documents that willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. R1's electronic medical record documents the following diagnoses: Schizophrenia, Major Depression, Dementia, EPS, HTN, Thrombocytopenia, GERD, Hypercholesterolemia, BPH, Dysfunction of the bladder, chronic kidney disease stage four. R1's current care plan documents that R1 is delusional daily. He also experiences auditory hallucinations to which he responds. Often, he becomes agitated at the voices and will yell and curse. R1's Brief Interview for Mental Status, dated 5/5/24, documents a score of 14, indicating the R1 is alert and oriented to person, place, and time. R1's Progress Notes, dated 7/22/25, document that resident (R1) was involved in an altercation with a peer (R2) while outside on the smoking patio. (R1) was lying on the patio, stating his hip hurt. (R1) was lying on his left side near his wheelchair on the pavement of the smoking patio. (R1) stated that his right hip hurt; however, he was lying on his left side. (R1) stated that he was unable to stand up due to the pain. Orders were received to send (R1) to the emergency room for an evaluation.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032763	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 2 R1's Emergency Room Notes, dated 7/22/25, document that R1 presented after a ground-level fall when one of the residents of his nursing home pushed him out of his wheelchair and he fell to the ground on his left side, leading to a complex left hip fracture. The Patient states that he does not want to return to the SNF (skilled nursing facility) because of the other residents. R1's Radiology Report, dated 7/22/25, documents a complex fracture of the left hip including both intertrochanteric and suspected basicervical components. Femoral foreshortening and coxa vera deformity at the left hip. R2's electronic medical record documents the following diagnoses: Encephalopathy, Diverticulosis, Mood Disorder, Paraphilia, Seizures, Heart Disease, Chronic Embolism and Thrombosis, Toxic effect of alcohol abuse, and Obsessive Compulsive Disorder. R2's current care plan documents that R2 has a behavior problem: (R2 has a history of socially inappropriate behaviors. (R2) can be verbally and physically aggressive, intrusive, and property destruction. (R2) displays a delusional thought process as to his limitations and effects on self, others, and surroundings, as well as the safety of self and others. R2's Progress Notes, dated 7/22/25, document that R2 had an incident with a peer (R1) this morning. (R2) stated that the peer (R1) was "Saying stuff that pissed me off and that's all I'm going to say." On 7/25/25 at 10:45am, R4 stated that R1 and R2 were bickering back and forth on the patio. R4 stated that all of a sudden, R2 got up and dumped R1 out of the wheelchair onto the concrete. On 7/25/25 at 11:00am, R3 stated that R1 was sitting in his wheelchair with his back to the wall, confused and yelling out. R3 also stated that R2 was sitting with his back to R1, yelling back at R1. R3 stated that R2 got tired of listening to R1, so R2 got up, pushed R1's wheelchair in front of the patio door, and tipped him out of the wheelchair. R3 stated that he got between R1 and R2. R3 stated that he got punched in the face during the altercation. R3 verified that R1 was yelling in pain and could not get up. On 7/25/25 at 1:00pm, V3, Administrative Quality Assurance/Grievance/Abuse Coordinator, stated that the majority of the resident population has a traumatic	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0032763	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 3 brain injury, so they are impulsive. V3 stated that this incident was an impulse, not abuse. (A)	S9999		