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 07/21/2025

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 Investigation 2526549/2565010	S0000		08/06/2025
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	S9999		08/06/2025

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

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S9999	Continued from page 1 t) 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 prevent resident-to-resident physical and sexual abuse and failed to implement abuse risk assessment and care plans for four of four residents (R1-R4) reviewed for abuse in a sample of four. This failure resulted in R1 sustaining a left femoral neck fracture, requiring surgical intervention. Findings include: The Abuse Prevention Program Facility Policy, revised 12/18/24, documents that the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, and involuntary seclusion. This form also documents that abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Instances of abuse of all residents, irrespective of a mental or physical condition, cause physical harm, pain, or mental anguish. This form documents that 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 behaviors through corporal punishment. Sexual abuse is non-consensual sexual contact of any type with a resident. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. Resident Assessment: as part of the resident social history evaluation and MDS (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 that would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. 1. R1's electronic medical record documents the following diagnosis: Schizophrenia, Dementia, Mood Disorder, Dyskinesia, Hypertension, and Seizures. R1's Mini Interview for Mental Status, dated 5/16/25,	S9999		

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S9999	Continued from page 2 documents a score of 3, indicating that R1 is severely cognitively impaired. R1's Progress Notes, dated 7/15/25, documents that R1 was involved in a physical altercation with a peer (R2) while in the dining room during breakfast. During this altercation, (R1) fell to the floor and stated his right leg hurt and that he was unable to stand up. This form documents that orders were received to send R1 to the emergency room for an evaluation. R1's current care plan documents, "(R1) may be belligerent at times and difficult to redirect. (R1) may walk into staff offices and take drinks, snacks, and money from desks or may take drinks and snacks from peers at times, (R1) also may take items from peers' trays." (R1's) intervention documents to anticipate (R1's) needs: food, thirst, toileting needs, comfort level, body positioning, and pain. R1's care plan also documents that R1 has memory impairments and displays poor impulse control, poor insight and judgment, poor decision making, which caused him serious difficulty interacting with others. R2's current electronic medical record documents the following diagnosis: Intracranial Injury, Facial Weakness following a Cerebral Infarct. Insomnia, Major Depression, Thrombosis, and Hyperlipidemia. R2's Progress Notes, dated 7/15/25, documents that R2 was involved in a physical altercation with a peer while at breakfast in the dining room. (R2) was not injured during this altercation, however, the other peer (R1) was injured; therefore, the Police were called and responded to the facility. R2's current care plan documents that R2 displays impulsivity, verbally/physically aggressive behaviors, false allegations, refuses meds, and feels that he does not need them. (R2) displays poor planning, poor insight, judgment, and decision-making ability, poor stress and emotion management, poor coping skills, and impulsivity. (R2) is very reactive to his surroundings. (R2) holds fast to/fixates on perceptions. (R2) is not easily redirected. (R2) feels his behaviors are appropriate/acceptable for any setting. The facility's Incident Description, dated 7/15/25 at 8:45am, that R1 attempted to take R2's oatmeal off his	S9999		

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S9999	Continued from page 3 tray. R2 pushed R1 away from the table, R1 lost his balance, and ended up falling. R2's signed statement, dated 7/15/25, documents "I (R2) pushed (R1) because he took my oatmeal. I am sorry I pushed him. I didn't push him hard, he just lost his balance". V5, Certified Nursing Assistant's, signed statement, dated 7/15/25, documents that (R1) took his breakfast tray to the trash, turned around, and grabbed (R2's) oatmeal off his tray. (R2) shoved (R1) to the floor. Staff immediately intervened. R1's Emergency Room Note, dated 7/15,25, documents R1 presented for left hip pain after a fall. (R1) was reportedly assaulted at the SNF (skilled nursing facility), and pushed to the ground by another resident over what each individual had for breakfast. R1's X-Ray of the left femur, dated 7/15/25, documents a transcervical femoral neck fracture with a 1-centimeter superior dislocation without significant angulation. (R1) was admitted to the Orthopedic surgical unit. On 7/19/25 at 11:00am, R2 stated that he was eating breakfast in the dining room when R1 grabbed his oatmeal. R2 stated that he attempted to grab his oatmeal back and pushed R1's hands away. That is when he lost his balance and fell. On 7/19/25 at 2:00pm, V4, Hospital Liaison, stated that R1 was admitted to the hospital with a fractured left hip, requiring surgical intervention. V4 stated that R1 has exhibited a decline in condition since being at the hospital. V4 stated that R1 was ambulatory before the fall. V4 stated that R1 will not stand and requires a mechanical lift for transfers. V4 verified that R1 will require several weeks of physical therapy. 2. R3's electronic medical record includes the following diagnosis: Intracranial Injury, Anxiety, Psychophysiological Insomnia, Traumatic Brain Injury, Antisocial Personality, Bipolar with Manic Severe, with Psychotic Features, Explosive Disorder and Cognitive Disorder.	S9999		

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S9999	Continued from page 4 R3's Brief Interview for Mental Status, dated 3/17/25, documents a score of 3, indicating that R3 is severely cognitively impaired. R3's current care plan documents that R3 displays socially/sexually inappropriate behaviors; inappropriate comments, attention seeking, child-like behaviors at times. R3's Progress Notes, dated 7/17/25 at 4:05pm, documents that R3 had his hand in the back of another resident's pants. This incident was only no longer than a few seconds according to the CNA (V6/Certified Nursing Assistant) that reported the incident. The facility's Incident Description, dated 7/17/25, documents that (R3) was at roommates (R4) bedside with what looked like inappropriate touching. Staff intervened and R3 was redirected away from R4. The incident lasted a couple of seconds. Environmental interventions was done with a room move. R3 was moved off of C wing to the end of E wing. R3 and R4 were placed on 15-minute checks. V6's Certified Nursing Assistant, signed statement, dated 7/17/25, documents that "(R3) was holding the hand of (R4), which I didn't find suspicious, then I went to see what (another resident) needed in his room, and when I came out of the room, I looked back in (R4's) room and saw (R3) with his hand down the (incontinent brief) of (R4)." On 7/19/25 at 4:50pm, V6 verified that he checked R3 and R4 before assisting another resident. V6 stated that when he was walking back down the hall he looked into R3 and R4's room. V6 saw R3 with his hand down the back of R4's brief. V6 stated that he separated R3 and R4, then reported the incident. V6 verified that R3 was moved to another unit immediately. R1-R4's medical records did not contain abuse risk assessments or abuse risk care plans. On 7/21/25 at 10:30am, V1 verified that abuse risk assessments were not done as the policy documents,	S9999		

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S9999	Continued from page 5 because of the population. V1 verified that the incidents between R1-R4 did happen. (A)	S9999		