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 09/03/2025

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 Annual Licensure and Facility Reported Incident of 8-29-25/2606057	S0000		09/16/2025
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and	S9999		09/16/2025

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

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S9999	Continued from page 1 timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to initiate and implement safety interventions for a resident who was on a restricted pass due to impaired thought process and poor safety awareness to prevent an elopement, failed to ensure staff were educated on identifying residents with restricted passes to leave the facility, failed to assess a resident after elopement, and failed to educate staff or implement additional safety interventions once a resident eloped for three (R37, R72, and R75) of four residents reviewed for elopement. These failures resulted in R75, who the facility identified as not being capable of unsupervised outside	S9999		

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S9999	Continued from page 2 pass privileges due to poor safety awareness, impaired thought process, and psychiatric diagnoses (including Schizophrenia), from exiting the facility without staff knowledge or supervision on 8/24/25 when R75 left the grounds in a Taxi. Findings include: The facility's Elopement Protocol/Missing person policy updated 4/23/25 documents upon locating the resident, the search coordinator initiates the following activities as appropriate: Direct that an assessment be initiated on the resident, notify family that resident was found, complete appropriate documentation in the resident's medical record, any in-services deemed needed by those involved in process. Immediately upon a residents return to the facility following an elopement/wandering episode, the resident shall be placed on elopement/wandering precautions. The nurse on duty shall review the facility sign-out procedure with the resident immediately upon return to the facility. Designate staff to monitor the resident's whereabouts, such as implementing 15-minute checks. The time periods for monitoring to be determined by the IDT (Interdisciplinary Team) with input from the staff. The above applies for a minimum of 24 hours at which time a reassessment will be made by IDT regarding any continuance. Should the resident be noncompliant with precautions, the procedure shall be extended for additional time as indicated by IDT. The management staff are to review all documentation as indicated. The facility's undated Resident Pass Policy documents each resident will be evaluated for community access at their initial MDS (Minimum Data Set) assessment. All residents will have no pass until that time. New residents that need to leave the building during this probationary period should do so with staff and/or family. The IDT will review and determine the individual's ability to access the community with or without staff/family. Residents going out on pass must sign out with the front door monitor prior to leaving. 1) R75's Nurse Progress Note dated 8/24/25 documents "Resident has left the facility on a pass violation. She called herself a cab, walked out the front door and got into the cab before staff could stop her. Staff tried to stop the car, but the resident was inside yelling drive, drive, drive. Another nurse called the cab company, and they stated they would be on their way back to drop the resident back off." R75s Pines Community Access Assessment dated 8/13/25 documents R75 is not capable of unsupervised outside	S9999		

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S9999	Continued from page 3 community passes related to Schizophrenia Disorder. This same assessment documents R75 does not know the facility address or how to contact someone in case of an emergency. R75's Psychiatric Evaluation dated 6/10/25 documents that R75 struggles with medication compliance and experiences paranoia. The evaluation documented a recent psychiatric hospitalization in February 2025 due to paranoia. R75 was noted to have a history of delusions, including beliefs that her food was being poisoned, and reported auditory hallucinations involving voices that conveyed negative messages. The assessment further described R75 as having poor insight and judgment, along with a scattered thought process. R75's psychiatric history includes diagnoses of Disorganized Schizophrenia, Bipolar II Disorder, Delusional Disorder, Personality Disorder, and Anxiety. R75's Medical Diagnosis List documents R75 has Paranoid Schizophrenia, Anxiety Disorder, and Personality Disorder. R75's mobility assessment dated 8/7/25 documents R75 is independent with ambulation. On 8/26/25, review of R75's current care plan did not include safety interventions related to R75's restricted community pass status and did not contain documentation of R75's pass restriction, despite prior assessments identifying R75 as incapable of unsupervised community access due to impaired thought process, poor safety awareness, and multiple psychiatric diagnoses. On 8/26/25 at 10:30 PM, R75 was observed ambulating independently within the facility. During the observation, R75 stated she remembered calling a taxi to pick her up on 8/24/25 and said she "was trying to leave the facility to go anywhere but here." R75 further stated she disliked being at the facility, describing it as "too loud" and that "there is too much going on." R75 then asked, "Can you help me get out of here?" On 8/27/25 at 8:45 AM, V20 (Social Services Director) stated she conducted R75s Community Access Assessment on 8/13/25 which revealed R75 had poor decision-making skills and poor safety awareness. V20 stated R75 is very paranoid and V20 does not believe that R75 would be able to ask for help or know where to go if R75 left the facility alone. On 8/27/25 at 9:15 AM, V9 (Registered Nurse) stated	S9999		

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S9999	Continued from page 4 that on 8/24/25, R75 called a taxi using her personal cell phone and exited the facility without staff supervision. V9 stated that staff attempted to prevent R75 from entering the cab, but R75 got into the vehicle and instructed the driver to leave yelling “drive, drive”. V9 reported she contacted the cab dispatch company to inform them that R75 was a resident of the facility, did not have funds to pay for the ride, and needed to be returned. The cab driver subsequently returned R75 to the facility. V9 stated she did not document the incident in R75’s medical record because V2 (Director of Nursing) indicated she would chart the note. V9 further stated that she did not chart the event due to staffing shortages and high workload on 8/24/25. On 8/27/25 at 9:15 AM, V24 (Security) stated he arrived at the facility around 3:00 PM on 8/24/25. V24 stated he observed R75 standing outside the facility using a cell phone but did not consider the behavior unusual. After clocking in, V24 returned outside and witnessed R75 entering a taxi. V24 reported yelling, “Hey, you can’t leave, you don’t have a pass,” but R75 instructed the driver to “go, go,” and the taxi departed. V24 stated he informed facility staff that R75 had left the grounds in a taxi. Staff subsequently contacted the taxi company to report that R75 was not authorized to leave the facility and did not have funds to pay for transportation. R75 was returned to the facility at an unknown time after. V24 confirmed that the front desk maintains a binder listing residents with community passes and those with restricted status. V25 also stated that all residents are required to check in with security and sign out before leaving the facility. On 8/27/25 at 9:30 AM, V25 (Security) stated he was assigned to the front entrance on 8/24/25, the date of R75’s elopement. V25 stated he was not familiar with R75 and asked, “Is she a new resident?” He further explained that he typically works in housekeeping and is occasionally reassigned to the front desk for security duties. V25 stated he does not know all the residents and did not recall any residents leaving the facility on 8/24/25. V25 confirmed that a binder is kept at the front desk listing residents with restricted and community passes. However, he was unaware that R75 had exited the facility while he was on duty. On 8/27/25 at 3:00 PM, V32 (Taxicab Manager) stated on 8/24/25 at 2:01 PM, the first call was received from (R75) to be picked up from the facility. The driver attempted to call her back but did not get an answer, so he did not go to pick her up. The next call was	S9999		

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S9999	Continued from page 5 received at 3:11 PM to be picked up at the facility. R75 was picked up at 3:15 PM, and the driver brought her back to the facility between approximately 3:35 PM and 3:45 PM. On 8/27/25 at 9:20 AM, V16 (Certified Nursing Assistant) stated, “I have only worked at the facility for four months. I do not know all the residents in the building who are on pass or does not have a pass. There is a book located at the security desk that has a list of residents who do not have a pass. We (staff) cannot memorize every resident who does not have a pass. If a resident does leave who is not supposed to and arrives back at the facility, that resident would be on 15-minute checks. The 15 minutes are in point click care under “tasks” if the resident is on 15-minute checks. (R75) is one of them that is constantly going out the door. (R75) has never left the building to my knowledge, at least no one has told me that she has, and I have not seen where she has been on 15-minute checks at.” On 8/27/25 at 9:43 AM, V26 (Certified Nursing Assistant) stated “I am not sure who is on pass and who is not in this facility, there are too many residents. The security guard up front is typically the one who knows. I am not aware that (R75) left the facility. (R75) does go out the door a lot but typically she comes back in. I am not aware of any resident getting out of the facility. Honestly, no one communicates around here. If someone gets out, they don’t let us know. We might see them on a 15-minute check in our “tasks”, but we don’t know why they are on 15-minute checks. If it didn’t happen on the shift, I work then most of the time we are unaware of it.” On 8/27/2025 at 9:15 AM, V22 (Certified Nurse Assistant) stated she was not aware of R75 eloping on 8/24/2025. V22 stated this information was not passed onto her. V22 stated R75 “stays close to her roommate and pushes her roommate around in her wheelchair”. V22 stated R75 does express she wants to leave frequently. V22 stated she does not know what R75’s ground pass is, but she knows she is new and assumes she is restricted because all new residents are restricted for a certain amount of time. V22 stated there is a book at the front desk that tells what each resident’s ground pass is or V22 said she will ask the nurse. V22 stated she was working 8/24/2025. V22 stated “some days are better than other days” when it comes to having enough staff. On 8/27/2025 at 9:40 AM, V23 (Registered Nurse) stated she was working on 8/24/2025 and was not aware that R75 had eloped, and the information was not passed onto	S9999		

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S9999	Continued from page 6 her. V23 does not know R75's ground pass, but she knows new admissions are to stay on the grounds for a certain amount of time. V23 stated she does not feel that she can monitor residents effectively because they are constantly short staffed. V23 stated if a resident does elope, she will try and find them, call the police if she cannot find them, and call the Director of Nursing and the Administrator, and the doctor. If a resident is still adamant about leaving, she will have them sign AMA (Against Medical Advice) paperwork and discharge themselves. V23 stated there is no protocol for elopement, and if there is she is unaware of the protocol due to not having any education. V23 stated 15-minute checks will be put in the residents' chart by the nurse, and the certified nurse assistants chart them in (Electron Medical Record). V23 stated she will still check the residents on 15-minute checks because some staff are "lazy", and she will make sure those checks are done. On 8/26/25 at 2:05 PM, V19 (Certified Nursing Assistant) stated that none of the floor staff were aware that R75 had exited the facility unsupervised on 8/24/25. V19 stated, "If we had known, we could have been monitoring (R75)." V19 further reported that there is a communication issue within the facility and that "management does not tell us anything." V19 explained that when a resident leaves the facility and returns, standard protocol includes assessing the resident, initiating monitoring, and documenting safety checks in the electronic medical record. V19 confirmed that these procedures were not initiated for R75 following her return on 8/24/25. On 8/26/25 at 12:30 PM, V4 (Licensed Practical Nurse) stated she was not aware that R75 had exited the facility in a vehicle on 8/24/25. V4 reported that unless staff are present during an incident, "most things are not passed along to the next shift." V4 stated that when a resident leaves the facility in violation of pass restrictions and returns, staff are expected to monitor the resident and document safety checks in the medical record. V4 confirmed that no documentation of safety checks was present in R75's chart following her return. On 8/27/25 at 2:30 PM, V31 (R75's family member) stated that approximately two to three months prior, R75 had left her former assisted living facility in a taxi and traveled approximately 48 miles and was later found at a bus stop. V31 reported that R75 is "very paranoid of people" and is not safe to be on her own. V31 stated that due to R75's impaired judgment and psychiatric history, the family chose placement in a long-term care	S9999		

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S9999	Continued from page 7 facility to ensure R75 received increased supervision and monitoring. V31 stated she was not aware that R75 had left the facility in a taxicab on 8/24/25. On 8/27/25 at 10:33 AM, R75's electronic medical record continued to lack updated safety interventions to prevent further elopement. The care plan did not reflect R75's restricted pass status or include monitoring strategies, despite the resident's recent unsupervised departure from the facility on 8/24/25. On 8/27/25 at 2:30 PM, R75 was observed entering the facility through the front doors from outside, following two other residents. This occurred without staff supervision or intervention, despite R75's documented restricted pass status and history of leaving the facility. R37's incident/accident report dated 8/29/25 at 12:00 PM documents R37 exited out the open side door located on the D/E hallway. R37 was observed in front of the facility standing near the main entrance. R37 was escorted back into the facility by staff. Physician, management, and family notified of incident via phone. On 9/3/25 V5 (Registered Nurse) stated on August 29, 2025, at approximately 12:00 PM, V5 was administering medications in the common area of the facility. At that time, an outside vendor was present, working on the heating and cooling unit. The vendor had propped open a door to facilitate their work. While V5 was engaged in medication pass, one of the vendors alerted V5 that someone had exited through the propped door. V5 immediately proceeded outside, walking along the sidewalk between the buildings to investigate. Upon returning to the front of the building, multiple staff members informed V5 that Resident R37 had already re-entered the facility. On 9/3/25 at 8:50 AM, V1 (Administrator) stated that immediately following the incident in which Resident R37 exited the facility through a door propped open by an outside vendor, the facility's Outside Vendor Safety Policy was revised. The updated policy now requires that: A designated staff member must be assigned to monitor the area whenever an outside vendor is working within the facility. V1 confirmed that on 8/29/25 R37 and R72 both had restricted passes and were not to leave the facility without a staff member. On 9/3/25 at 9:15 AM, R37 stated he does not remember walking outside and walked away. R37 is independently ambulatory in the facility.	S9999		

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S9999	Continued from page 8 On 9/3/25 at 9:00 AM, R72 stated he saw R37 step out the door so R72 followed R37 to make sure he didn't leave. R72 stated he yelled for staff when he saw R37 go outside. (B) 2 of 2 300.697d) Section 300.697 Infection Preventionalist d) Facilities with more than 100 licensed beds or facilities that offer high-acuity services, including but not limited to on-site dialysis, infusion therapy, or ventilator care shall have at least one IP on-site for a minimum of 40 hours per week to developand implement policies governing control of infectious diseases. For the purposes of this subsection (d), "infusion therapy" refers to parenteral, infusion, or intravenous therapies that require ongoing monitoring and maintenance of the infusion site (e.g. central, percutaneously inserted central catheter, epidural, and venous access devices). These requirements were not met as evidenced by: Based on interview, and record review the facility failed to ensure the Infection Preventionist was allocated at least 40 hours per week for infection prevention at a facility with more than 100 licensed beds. This has the potential to affect all 110 residents who reside in the facility. The facility's Infection Control Coordinator policy, not dated, documents, "The infection Control and Prevention Program is spearheaded by a person assigned by leadership to be responsible for development of the activities involved in the management and promotion of the infection prevention, who shall be called the Infection Control Coordinator. The Infection Control Coordinator shall be accountable for the Infection Control and Prevention Program within the organization. The Infection Control Coordinator will routinely review rising trends and recommendations from outside resources such as public health organizations, infectious disease doctors, and consultant." On 8/27/2025 at 2PM, V3 (Infection Preventionist) stated she is the infection preventionist and she is the care plan coordinator. V3 also stated she goes over to Sharon Health Willows to help them for a half of a day two days a week. V3 stated she spends about 30 hours a week on infection control.	S9999		

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S9999	Continued from page 9 The facility's Center's for Medicare and Medicaid Services Long Term Care Application dated 8/25/25 and signed by V1 (Administrator), documents there are 110 residents residing in the facility. (C)	S9999		