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 C B. WING IL6007298 06/30/2022 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Incident Report Investigation of 6/15/22/IL148299 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240e) 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 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 Attachment A care and personal care shall be provided to each Statement of Licensure Violations resident to meet the total nursing and personal care needs of the resident.

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ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	Department of Public	Health		. #5.	FOR	MAPPROVED
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	IPLE CONSTRUCTION	Toyou - w	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IG:		TE SURVEY	
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NABACO					06	/30/2022
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			00000			1
	Section 300.3240 A	huse and Noglost				
	00000011000.0240 7	rouse and Mediect				
	e) When an inv	estigation of a report of				<u> </u>
	suspected abuse of	a resident indicates, based				1 1
	upon credible evide	nce, that another resident of	}			
	the long-term care f	acility is the perpetrator of the				47
	abuse, that resident	s condition shall be	·	·		
	immediately evaluat	ed to determine the most		ì		
	onsidering the safe	placement for the resident, ty of that resident as well as				500
	the safety of other re	esidents and employees of				
	the facility. (Section	3-612 of the Act)				1
		o o i z o i i i o Acij				1 . 1
	These requirements	are not met as evidenced by:		(2)		
	Based on interview a	and record review the facility		· · = = w =		11 9900
	failed to prevent sex	ual abuse for two of three		·		1
	residents (R4 and R	5) reviewed for abuse in the				
	sample of three. Thi	s failure resulted in two				
	cognitively impaired	(non-consenting) residents		1		1
	with the diagnoses of	f Brain Injuries (R4 and R5)		30		ė.
	being found in K4 an	d R5's room with door		£4.		
	danaling off with a ful	in his bed with his legs Il erection and R5 performing		·		
	oral sex on R4.	i erection and R5 performing				
	,	- 9				
ł	The facility's Abuse P	revention Program Facility				
	Policy undated, docu	ments, "This facility affirms				
	the right of our reside	nts to be free from abuse,	. 9	820		
ĺ	regiect, exploitation,	misappropriation of resident		* **		
	seclusion. This facilit	nishment, and involuntary				
	mistreatment neclect	t, or abuse of its residents,			,	
	and has attempted to	establish a resident				
	sensitive and resident	secure environment. The				ı
	purpose of this policy	is to assure that the facility				
J 1	is doing all that is with	in its control to prevent				
	occurrences of mistre	atment, neglect, or abuse of			* * * *	
	our residents. Abuse	means any physical or				

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		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		_	
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	¥1.	resident other than I Abuse is non-conse type with a resident.	ual assault inflicted upon a by accidental means. Sexual nsual sexual contact of any Sexual abuse includes, but ual harassment, sexual assault."		****(=			1 85.1		
	D4	According to R4's cu Sheet), R4 has diagonal Ischemic Encephalo Pseudobulbar Affect	urrent POS (Physician Order noses of Moderate Hypoxic pathy, Depression, , and Hemiplegia.	.e	. N 1 2 3±					
	***	dated, 6/20/22, docu Interview of Mental S	Data Set) Assessment ments R4 has a BIMS (Brief Status) of 06 (cognitively apletely dependent on staff of Daily Living).		×	40				
		plan revised 10/20/21 need to be taken to a	d Cognitive Function care 1, documents, "(R4) may a quiet area to assess message related. (R4) ent, simple, directive			# 4				
		on 1/12/22, documen related to traumatic b dependent on staff". Encourage (R4) to do	Mobility plan of care revised ts, "Limited Physical mobility rain injury and is completely Interventions include: " ROM/Range of Motion with es, assistance with ROM as				111	* >		
	r ii d	locuments, "May be renedications, anxious nappropriate at times los not specify the in	." This same plan of care)• ***				3	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET AD			DRESS, CITY, S	TATE, ZIP CODE		06/30/2022	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLE DATE	
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Ş	According to R5's cudiagnoses of Intracreto the facility on 6/15/6/16/22.	urrent POS, R5 has anial injury and was admitted 5/22 and discharged home on					
	R5's Interim plan of documents R5 is ind walker and did displate behavior on admission	ependent ambulating with a					
	Health) Final Notifica incident of 6/15/22, s documents, "Name o Neglected: (R4). Dia	llinois Department of Public tion Investigation Report for igned by V1(Administrator), of Resident Abused or ignosis and Mental Status: Injury), Anoxic Brain Injury					
i	(R4) oriented times on third shift in reside (R5) was potentially so (R4). CNA/Certified I walked in on incident on incident (R4).	ent (R4's) room, roommate sexually inappropriate with Nursing Assistant (V11) during facility round. No R4). During the process of record review and interview			-		
r	of witnesses the follow No history of sexually new admit (R5). (R4) nappropriate behaviound inappropriate tou	wing facts were determined: inappropriate behavior with has a history of sexually ir including exposing himself ching with staff. Based on following conclusions have					
b F W e c	een determined abor Residents (R4 and R5 vith (R5) performing o vidence to confirm al onsent so residents' Iterrupted and separa	ut the original allegation: 5) engaged in a sexual act oral sex on (R4), no buse but unable to assess (R4 and R5) were ated. The following Actions					
ta in ni	aken based on the fa	cts and conclusion of the ved to another room for the ot comfortable and					

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 B. WING IL6007298 06/30/2022 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 (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 Awritten investigation report dated 6/16/22 and signed by V5 (Social Service Director) documents, "I had a one-on-one interview with (R5) regarding the incident that happened with (R5's) roommate (R4). (R5) stated '(I) was just in my room and my roommate pulled his sheet down and started rubbing himself until he was 'hard' looking at me, so (I) just did it and (R4) liked it." On 6/24/22, at 11:55 am., V1 (Administrator) stated, "I did an investigation regarding (R4) and (R5). (R4) has sexual behaviors of exposing himself at times. (R4) has exposed himself to me. I did not receive any information on or before admission about any sexual behaviors by (R5)" On 6/25/22 at 6:30 pm., V7 (CNA/Certified Nursing Assistant) stated, "(R4) cannot speak but does shake his head yes and no and does understand what we are asking. (R4) sometimes won't respond to certain staff or people but will if he wants to. (R4) really likes V11/CNA and will always respond to her.' On 6/24/22 at 6:45 pm., V11 stated she has taken care of R4 for years. V11 stated R4 will communicate with her by shaking his head yes or no and does understand cognitively. V11 stated. "(R5) was admitted on 6/15/22. (R5) was put in (R4's) room as roommate. I was doing rounds that night and knocked on (R4) and (R5's) door and then opened it and walked in. (R4) was lying in the bed with his legs dangling off the bed with a full erection. (R5) was bent over performing oral sex on (R4). (R4's) eyes were big and he looked scared and didn't know what to do. I said what are you doing and (R5) stopped at this time and crawled back to bed. I asked (R4) if he would

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-	head no. I separate (V10/RN/Registere another room for th any sexual activity	happen and he shook his did the two and got the nurse Nurse). We moved (R5) to e night. (R4) has never had with any other males or has		12 41			
- Par	tried to. (R4) would wanted to, (R4) is to also stated (R5) wa was independent wi	not be able to stop (R5) if he otally dependent on staff. V11 s somewhat confused and ith ADL's.			- 6: =		
t the	wheelchair and did arms and legs and wifeely per self. R4 responded to the whole when asked if some him, (R4) responded shook his head no woral sex.	om., R4 was sitting in his not have full ROM with his was unable to move around esponded to questions asked yes and no. R4 shook his apple questions. When asked anything to him, he did not by shaking his head yes. Sone performed oral sex on a shaking his head yes. (R4) when asked if he wanted the					
	stated, "R5 has beer time he was 24 and is behaviors of flirting was grabbing the nurses reports of sexual mis any residents and ce residents. (R5) was and it has never beer contact with any of the that this even happer male, as he would have brain injury. (R5) liking women and new this even happened. home with me. V12 and behaviors of the work of the thing women and new this even happened.	am., V12 (R5's mother) in a group home from the s now 53. (R5) has had with women and sometimes but I have never got any conduct from (R5) towards rtainly not any male in a group home with all men in reported to me any sexual em. (I) am shocked to hear ned especially with another enever done this prior to has always talked about ver any men. (I) am upset (R5) is now living back at also stated (R5) has a brain temember things of short					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6007298 B. WING 06/30/2022 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 6 S9999 term and would not remember if that happened." On 6/25/22 at 10:28 am., R5 was oriented to place but not date or time. When asked if R5 remembered staying at a local nursing home for one night approximately one week ago, R5 responded no. R5 stated he lived at (the group home) and now lives at home. R5 stated he did not have oral sex with a male and would never do that. R5 stated "I like women not men." On 6/26/22 at 1:58 pm., V13 (LPN/Licensed Practical Nurse) stated, "(R4) is not capable of protecting himself. No way (R4) could have stopped (R5) from the sexual incident." On 6/27/22, at 2:00 pm., V2 (DON/Director of Nursing) stated, "(R4) has inappropriate sexual behaviors of pulling it out "penis" wherever he is sitting rather it be in the dining room, television room, or his own room." On 6/27/22 at 2:05 pm., V14 (ADON/Assistant Director of Nursing) stated, "(R5) was alert but had very short memory. (R5) upon admission kept grabbing at me and I would redirect his and he would then do it again. Then all the sudden (R5) would say 'my name is (R5) what's your name.' (R5) didn't know what he answered a few minutes after he was asked questions." On 6/27/22 at 2:15 pm., V15 (Care Plan Coordinator) stated, "When (R5) was admitted (R5) kept groping at the CNAs constantly. (R5) would have to be directed constantly, he was alert but confused. V15 also stated (V4) was care planned for sexual inappropriate behaviors before I was here, I have only known him to pull down his covers at times. He really can't do anything but slide down in his chair. Knowing (R4) I don't

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If continuation sheet 8 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED C IL6007298 B. WING 06/30/2022 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 7 S9999 S9999 think he would have liked (R5) having oral sex on (B) nois Department of Public Health **FATE FORM**

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