Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007298	A. BUILDING: ______ B. WING ______	R-C 09/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE PINES	3614 NORTH ROCHELLE PEORIA, IL 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) COMPLETE DATE
S 000	Initial Comments First Revisit to Survey date 8/15/23, Facility Reported Incident IL162918/ of 8/1/23.	S 000		
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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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care needs of the resident.

Section 300.3210 General

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 observation, interview, and record review the facility failed to protect and prevent physical abuse during resident-to-resident altercation for two (R1 and R7) of four residents reviewed for abuse in the sample of four resulting in R1 obtaining a laceration to top of his head that required six sutures.

Findings include:

The facility's Abuse Prevention Program policy, reviewed 8/22/23, documents "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents." "This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals." This same

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S9999	Continued From page 2 policy defines abuse as: "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." "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." The facility's Final Abuse Investigation Report, dated 9/1/23, documents a physical altercation between R1 and R7 occurred in the AB (hallways) television area on 8/28/23 at approximately 8:25 pm. R1 was sent to the local hospital and received sutures. Video surveillance reviewed which showed R7 entering the AB television room and turned off the television that R1 was watching. Negative verbal name calling was exchanged by R1 and R7 resulting in R7 striking R1 with his hand and a cup and R1 engaged in physical contact. Staff immediately intervened. "Based on the known facts, the following conclusions have been determined about the original allegation: Incident occurred. (R7) and (R1) both suffer from TBI (traumatic brain injury), and both exhibit secondary to Dx (diagnosis), poor impulse control, poor coping and poor decision making abilities. This was a reactionary event with no premonition." The Incident/Accident Report for R1 and R7, dated 8/28/23, document a physical altercation occurred between R1 and R7. R1 "sustained an approximate one inch skin tear to the right top of scalp" and was sent to a local hospital by ambulance stretcher. R7 had no visible injuries.	S9999		

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The local hospital Discharge Summary, dated 8/29/23, only documents "Keep dry for 24-48 hours, can leave uncovered, have removed in 10-14 days. Return to ER (emergency room) if you get fever, pus drainage, redness, or any other concerns."

The Progress Notes for R1, dated 8/29/23 at 4:38 am, documents "Received call from (local hospital), related to patient leaving without discharge papers. Patient to keep 6 sutures to forehead clean/dry, do not get wet, Remove sutures in 10-14 days."

On 9/15/23 at 9:30 am, V1 Administrator confirmed there was an altercation between R1 and R7 on 8/28/23, R7 hit R1 on the head resulting in R1 receiving sutures to his head and both residents were referred to psychological services for follow up.

On 9/15/23 at 10:00 am, R1 stated he had been watching television and R7 came in the room, unplugged the television, started calling (R1) names, and started hitting (R1) on the head with a metal cup. R1 stated "I had to go to the hospital and get six stitches to my head. It was very painful and is still sore to touch."

On 9/15/23 at 11:00 am, R7 stated someone asked him to turn the television down and "I unplugged it by accident." R7 stated R1 called (R7) a "B**ch" and R7 told him he wasn't going to call him that. R7 stated R1 stood up from (R1's) wheelchair, called (R7) names and kept asking (R7) what (R7) was going to do about it. R7 stated "I walked right up to him (R1) and hit him (R1) right on top of his head with my metal cup. He had to get stitches, six or seven of them."

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Smiling, R7 stated "I had to defend myself. I was in the service, and we are to have respect. Can't be calling me names like that."

On 9/15/23 at 4:10 pm, V6 SSD (Social Service Director) stated R7 turned off the television that R1 was watching and when R1 asked R7 why he did it there were words exchanged and name calling and R7 struck R1 in the head with (R7's) cup and R1 was sent to the hospital and received stitches.

(B)