STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E322	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHARON HEALTH CARE PINES	**3614 NORTH ROCHELLE PEORIA, IL 61604**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to prevent physical abuse for one of three residents (R1) reviewed for abuse in a sample of three. This failure resulted in R1 being repetitively struck in the head and subsequently being hospitalized for [REDACTED]. Findings include: The facility Abuse Prevention Program Facility Policy dated 6/3/19 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. 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 corporation punishment. R1's current computerized medical record documents R1 remains hospitalized at a local hospital since the resident to resident physical assault which occurred on [DATE]20. An Incident/Accident report dated [DATE]20 at 7:00 p.m. documents R1 was located on the unsupervised smoking patio and that R6 (witness) reported that R2 punched R1 and pulled her out of her wheelchair onto the ground. R1 was sent to the local hospital and R2 was arrested and taken to jail. R1's local hospital admission record dated [DATE]20 documents R1 was intubated and transferred to the intensive care unit. R1's CT (Computed Tomography) of the brain dated 2/25/2020 indicates Critical Result of New [MEDICAL CONDITION] Identified. On 3/3/2020 at 9:55 a.m., R6 stated that (R1) keeps coming out on the patio where she is not supposed to be and (R1) called the new girl (R2) some bad name and cussed her out and then (R1) threw her helmet at (R2) and then (R2) took the helmet and kept hitting (R1) in the head until I yelled stop. On [DATE] at 12:45 p.m., V2 (Director of Nursing) verified that an unwitnessed resident altercation occurred on [DATE]20 between R1 and R2. On [DATE] at 10:55 AM, V1 (Administrator) stated: (R1) is always getting out onto the unsupervised smoking patio, where she isn't supposed to be, and either soliciting cigarettes for money or trying to bum a cigarette and that is why the altercation happened.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide supervision to prevent a resident to resident altercation for two of three residents (R1, R2) reviewed for supervision in the sample of three. This failure resulted in R2 physically assaulting R1 and R1 being hospitalized for [REDACTED]. Findings include: A facility Smoking Safety Policy and Procedure dated 6/3/19 documents: Supervision, in addition to periodic observation, regular checks are made by staff of the patio smoking area at the time of the scheduled passes. A Facility Smoking Report (undated) documents, that both R1 and R2 are Managed (Supervised) smokers and can only go out to smoke with supervision. An Incident/Accident report dated [DATE]20 at 7:00 p.m. documents R1 was located on the unsupervised smoking patio and that R6 (witness) reported that R2 punched R1 and pulled her out of her wheelchair onto the ground. R1 was sent to the local hospital and R2 was arrested and taken to jail. On [DATE] at 11:56 a.m. V3 (Registered Nurse) stated that on [DATE]20 in the evening, she was doing a medication pass for approximately 50 residents when a certified nursing aide came up to her and said there is a fight on the unsupervised smoking patio. V3 stated One of the residents was yelling fight, fight and (R1) was on the ground in front of her wheelchair. I took R1's vitals and kept her on 15 minute neurological checks and within an hour or so she was not herself and her blood pressure was dropping and getting low, her respirations were more shallow and her neurological assessment (Glasgow coma scale) was a 7. (R1) became more lethargic so we called 911 and she was transferred out to a local emergency room . (R1) did not have her helmet on when I assessed her. The unsupervised smoking patio continues to be a problem, because I cannot keep my eye on all these residents and pass medications at the same time. (R1) should never be allowed to go out that door to the unsupervised patio so easily, the door is unlocked and she is able to push it out and open and then she is out there and you can't see her if you don't physically go out on the patio. I have mentioned that this is a problem and some of (R1's) altercations happen on the unsupervised smoking patio. R1's facility Smoking assessment dated [DATE] documents that R1 requires managed/supervised smoking materials, (R1) is on a managed smoking program. R2's facility Smoking assessment dated [DATE] documents that R2 requires managed/supervised smoking materials. R1's current computerized medical record documents R1 remains hospitalized at a local hospital since the resident to resident physical assault occurred on [DATE]20. R1's local hospital admission record dated [DATE]20 documents that upon arrival to the emergency room , R1 would not open her eyes to command, did not have a gag reflex, was not making any understandable words or noises, had bruising to her face, had a posttraumatic right frontal scalp hematoma and a critical result of new [MEDICAL CONDITION] identified. This same hospital record documents R1 was hypotensive on arrival with shallow respirations, R1 was intubated and transferred to the intensive care unit. R1's CT (Computed Tomography) of the brain dated 2/25/2020 indicates Critical Result of New [MEDICAL CONDITION] Identified. On [DATE] at 10:55 a.m. V1 (Administrator) stated: (R1) is always getting out onto the unsupervised smoking patio, where she isn't supposed to be, and was either soliciting cigarettes for money or trying to bum a cigarette and that is why the altercation happened. On 3/3/2020 at 9:55 a.m. R6 stated that (R1) keeps coming out on the patio where she is not supposed to be and (R1) called the new girl (R2) some bad name and cussed her out and then (R1) threw her helmet at (R2) and then (R2) took the helmet and kept hitting (R1) in the head until I yelled stop. On [DATE] at 12:45 p.m. V2 (Director of Nursing) stated that there are residents who are allowed to go out and smoke without supervision and they use the unsupervised (independent) smoking patio and can go in and out when they want because that door is unlocked at all times. V2 further stated that there are residents who require supervision and are only allowed to be on the Supervised (Managed) Smoking Patio during scheduled smoke break times. V2 stated: (R1) was not supposed to be out on the Independent Unsupervised Patio because she requires supervision when she goes out to smoke. (R1) is constantly getting out onto the unsupervised patio begging or bartering for cigarettes. The door to the unsupervised patio is located directly beside the nursing station in the main area, but that doesn't mean someone is always watching that door to see who goes in and out. It's impossible to supervise her at all times. On 3/4/2020 at 11:10 a.m. V5 (Case Manager) stated (R1) is not supposed to be out (on the unsupervised patio) and goes anyway and is

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) able to get out there before staff see her. (R1) has been known to throw her helmet and hit people and she should have better supervision. Even after redirected, (R1) will get right back out there on the unsupervised patio.