STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	C 11/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	**3611 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) COMPLETION DATE
F 000	INITIAL COMMENTS Original investigation of complaint#1626667\IL90005-F224 and F323 Original investigation of complaint#1626639\IL89977-F224 and F323	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility neglected to follow their mechanical lift policy in relation to proper placement of the lift sheet for one of three residents reviewed for falls in the sample of three. This failure resulted in R1 falling from a mechanical lift and sustaining a subdural hematoma, facial laceration requiring suturing, and a fractured femur. Findings Include: The (undated) Facility Policy, Using Portable Lifting Machine, instructs staff to, " Place the sling, fan-folded, along the back of the resident. Make sure the top of the sling is at the head of the resident and the bottom at the resident's knees."	F 224		12/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/14/2016

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 224	Continued From page 1 On 11/22/2016 at 8:30A.M., R1 was laying in bed with eyes closed. A laceration was noted to R1's mid-forehead with 8 sutures intact present. R1's CT (Computerized Tomography) of the head or brain from the local emergency room, dated 11/21/2016 at 7:20 P.M., documents the following: "Impression small acute left cerebral convexity subdural hematoma; Frontal scalp contusion; laceration; and likely containing foreign debris." R1's Imaging exam of the right femur, dated 11/21/2016 at 7:12 P.M., documents, "Closed fracture of the distal end of right femur." Z1 Primary Physician Progress Notes for R1, dated 11/22/2016 at 3:34 P.M., documents the following: "Recently fell off hoyer lift and sustained Right Femur Fracture and laceration to mid forehead; Patient (R1) was taken to local emergency room; She (R1) also sustained a subdural hematoma; and Patient (R1) not a surgical candidate and will not have ortho (orthopedic) surgery." On 11/22/206 at 11:10 A.M., E1 DON (Director of Nurses) stated the following: "After the investigation the only conclusion that I could come up with is that the mechanical lift sheet was positioned too far up resident's (R1) body, so when the CNA's (Certified Nursing Assistants) (E2 & E4) lifted resident (R1) up to transfer the resident (R1) slipped out of the sling; (R1's) feet touched the floor, then resident (R1) landed on R1's face and the CNA's were unable to catch (R1); and if the mechanical lift sheet was positioned correctly around and below (R1's)	F 224		

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F 224	Continued From page 2 hips, and close to (R1's) knees, (R1) would not have slipped out of the mechanical lift sheet." On 11/23/2016 at 11:10 A.M., E2 CNA stated the following: " The hoyer lift sheet that was underneath the resident (R1) was positioned too high above the hips and not close to R1's knees; the mechanical lift sheet is to be positioned closer down near the knees; when resident (R1) was being transferred (R1) slipped out of the mechanical lift sheet with feet landing on the floor, then (R1) fell forward hitting (R1's) face on the floor; and I did not check the placement of the mechanical lift sheet because I thought the other CNA had checked for correct placement." On 11/22/2016 at 11:10 P.M., Z1 Primary Physician stated the following: "Yes, resident (R1) fell to the floor from the hoyer lift and sustained a Fracture of the Right Femur, a Subdural Hematoma, and a laceration to the mid forehead; and this should not have happened, but we are keeping her comfortable."	F 224		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and	F 323		12/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 3	F 323		

interview the facility failed to properly position a resident in a mechanical lift sheet for one (R1) of three residents reviewed for falls in a sample of three . This failure resulted in R1 sustaining a subdural hematoma, a facial laceration, and right femur fracture when R1 fell out of the lift sheet during a transfer.

Findings Include:

The (undated) Facility Policy, "Using Portable Lifting Machine" instructs staff to "Place the sling, fan-folded, along the back of the resident. (Make sure the top of the sling is at the head of the resident and the bottom at the resident's knees.)"

On 11/22/2016 at 8:15 A.M., R1 was laying in bed with eyes closed, a laceration and contusion was noted near mid forehead with eight sutures in place, and bilateral lower extremities were contracted.

Z1 (R1's Primary Physician) Progress Notes dated 11/22/2016 at 3:34 P.M., documents the following: " (R1) recently fell off the hoyer lift and sustained a right femur fracture and laceration to the mid-forehead; patient (R1) was taken to the local emergency room; she (R1) also sustained a subdural hematoma; patient (R1) is not a surgical candidate and will not have Ortho (Orthoscopic) surgery; (R1) returned to the facility later in the day; and (R1's)laceration was repaired with 8 sutures and on bedrest."

R1's local hospital emergency room notes dated 11/21/206, documents the following: "Chief Complaint: Fall, Facial Laceration; and Diagnoses: Closed Fracture of the Distal End of Right Femur, and Forehead Laceration."

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F 323	Continued From page 4 R1's CT (Computerized Tomography) of the head and brain from the local emergency room ,dated 11/21/2016 at 7:20 P.M., documents "Small acute cerebral convexity subdural hematoma. Frontal scalp contusion, laceration and likely containing foreign debris. R1's Imaging exam of the right femur from the local emergency room,dated 11/21/2016 documents, "Closed fracture of the distal end of the right femur." R1's Accident/Incident report, dated 11-21-16, documents the following: "CNA notified me (E3) that resident (R1) was on the floor; when I (E3) walked into room, I observed resident (R1) laying prone (face down) with her head by the foot of the bed; I (E3) rolled resident (R1) over and performed an assessment; MAE (Moves All Extremities) without difficulty; I (E3) observed blood on resident's (R1) face and when I (E3) cleansed resident's (R1) face, I (E3) observed a laceration to the middle of (R1's) forehead; and I (E3) requested the assistance of eight other staff members." E1 DON (Director of Nursing) investigation synopsis, faxed to the local state department undated, documents the following on R1: "Please be advised that on 11/21/2016 at approximately 1:42P.M., resident (R1) was being transferred from a recliner chair to the bed via hoyer lift, and resident (R1) slid out of the hoyer sling landing on her (R1's) feet face first on the floor as reported by (E2) and (E4) both CNA's; (E3)LPN (Licensed Practical Nurse) reports that when (E3) entered the room (E3) observed resident (R1) laying in the prone (face down) position with head by the	F 323		

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F 323	Continued From page 5 foot of the bed; resident (R1) then was rolled over and an assessment was performed to determine that the resident (R1) had a laceration to the forehead that needed sutured; (Z1) R1's Primary Physician was notified and resident (R1) was sent to the local emergency room; resident (R1) was found to have a Left Cerebral Subdural Hematoma, frontal scalp contusion, and laceration; resident (R1) also diagnosed with Closed Fracture Distal End of Right Femur and no surgical repair to femur at this time due to the risks outweigh the benefits for repair; resident (R1) received six sutures to the laceration for repair and returned to the facility on 11/22/2016; employees involved in this have received a refresher in-service on the proper use of the hoyer lift; and both will receive disciplinary action related to the incident." On 11/22/2016 at 11:10 A.M., E1 DON (Director of Nurses) stated the following: "The mechanical lift sling was positioned too far up on resident's (R1) body; as the CNA's lifted (R1) in the mechanical lift sheet up, R1 slipped out of the sling; R1's feet touched the floor and then R1 landed on R1's face; and if the hoyer sheet was positioned around R1's hips and down near R1's knees, R1 would not have slipped out of the sling." On 11/23/2016 11:12 A.M., E2 CNA stated "The hoyer sling that goes underneath (R1) to transfer (R1) was positioned too high up near R1's head and buttocks, and it (hoyer sling) should be positioned close to R1's neck and go down near R1's back of the knees."	F 323		