STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007306	A. BUILDING: _____ B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 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		

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S9999	Continued From page 1	S9999		

care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 were not met as evidenced by:

Based on observation, interview, and record review the facility failed to conduct a resident assessment to determine the resident's degree of mobility, physical impairment and the proper transfer method needed once a resident experienced increased weakness. The facility also failed to maintain an adequate working electrical supply to adjust an electric bed into the lowest position prior to a transfer for one resident (R9) and failed to implement appropriate fall interventions for one resident (R8.) These failures affect two of three residents (R8, R9) reviewed for falls in the sample of 27. These failures resulted in R9 losing grip of the sit-to-stand mechanical lift handles and falling to the floor, sustaining a coccyx fracture and severe pain that required hospitalization.

Findings include:

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S9999	Continued From page 2	S9999		

a.) The facility's Job Description for CNA's (Certified Nursing Assistants), undated, documents "Illustrative Examples of Work: Care delivery to include, but not limited to: Bathing a minimum of two times weekly, daily oral hygiene, shaving, changing clothes, nail care, toileting feeding, ambulating, transferring, room care, hair care. Recognizing and reporting changes in condition to the nurse (example: health problems, eating problems, changes in skin or incontinence behavioral problems, unstable vital signs.) Maintain a safe environment for the residents and other staff. Follow safety practices (example: keeping resident areas hazard free, follow good body mechanics, wear proper footwear, use lifting devices according to manufacturer's directs, wear gait belt, etcetera.). General Employee Guidelines: Immediately report defective equipment, hazardous conditions, or supply shortages."

The facility's Fall Policy and Procedure, dated 1/2/2019, documents "It is the Policy of (the facility) to provide an environment conducive to reducing risk for falls. (The facility) provides interventions to reduce risk factors for filling but cannot guarantee or maintain a fall-free environment."

The facility's Transfer Between Surfaces policy, dated 3/2000, documents "Purpose: To improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. Procedure: 1. Explain and demonstrate procedure. 5. Bed should be flat and level with wheelchair seat."

The facility's Fall Prevention Practice, dated 1/10/2016, documents "Below is a list of things

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S9999	Continued From page 3	S9999		

that can help reduce the risk for falls: 8. Report changes in mental status to nurse immediately."

1. R9's Admission Record documents R9 is a 70-year-old male admitted to (the facility) on 5/14/2012 with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Difficulty in walking, Frontotemporal Neurocognitive Disorder, Dementia, Schizoaffective Disorder, Extrapyramidal and Movement Disorder, and Cerebral Infarction.

R9's Minimum Data Set (MDS) assessment dated 9/3/24, documents R9 has severe cognitive impairment, and requires substantial assistance for activities of daily living, toileting, and transfers.

R9's current Care Plan documents, "(R9) has the potential for falls due to increased weakness."

The facility's Maintenance Work Order dated 9/19/24 and signed by V7/CNA, documents R9's room had no electricity.

R9's Progress Note, dated 9/19/24 and signed by V15/RN (Registered Nurse), documents "(R9) was observed on the floor, lying on right side. Per two aides (Identified as V8/CNA (Certified Nursing Assistant) and (V9/CNA), they were attempting to get (R9) into bed. After a couple minutes, it was indicated that (R9) was to be moved back into chair due to the bed being unavailable for use. Throughout all of this, (R9) was in a mechanical stand lift and was already up at the highest position. Per (V8 and V9), (R9) began to drift down. (V8 and V9) stated that they pulled chair under (R9) but at that point (R9) was too low to get into his chair. Then (V8 and V9) stated that (R9) quickly slid through the straps due to him lifting his arms up, where (R9) then hit

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S9999	Continued From page 4	S9999		

the floor at fast and unexpected speed where (V8 and V9) were unable to slowly lower (R9). Different reports of if (R9) hit head or not, so per the physician, we (the facility) called emergency services to send (R9) out to the Emergency Room to be evaluated due to nature of fall. Per (V8 and V9) (R9) was lethargic. No signs of lethargy when this nurse assessed (R9). During assessment, (R9) stated that he was in extreme pain on right side of arm."

R9's Electronic Medical Record does not include evidence of a nursing assessment being performed when R9 was lethargic prior to be transferred from the wheelchair.

R9's Local Emergency Record, dated 9/19/24, documents "CT (Computed Tomography) pelvis for bone detail without contrast final result: Impression:1. Acute or subacute mildly displaced comminuted inferior coccyx fracture. This same form documents "Clinical Impression: Fall, Urinary Tract Infection, and Hyponatremia (low sodium level.)"

On 10/06/24 at 9:02 AM R9 was in self-propelling wheelchair around R9's room. R9 had nonskid socks on. R9 was unable to answer questions appropriately at this time.

On 10/7/24 at 12:04 PM V8/CNA stated, "(V9/CNA) and I were transferring (R9) from his wheelchair to the bed with a mechanical stand lift machine. (R9) was weak when (V9) and I were lifting him, so (V9) and I tried to get (R9) to the bed quickly. When (V9) and I attempted to transfer (R9) to the bed we realized the bed was too high. I then tried to use the controller to lower the bed while (R9) was trying to hold on and slipping from the sit-to-stand machine at the

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S9999	Continued From page 5	S9999		

same time. I realized the controller was not working to the bed, so (V9) and I attempted to turn him back around and put him in the wheelchair. By that time (R9) had let go of the sit-to stand and had fell to the ground." V8 verified at this time, that she should have not attempted to transfer (V8) when she realized he was weak and should have ensured the bed was working and in the proper position prior to transferring R9.

On 10/7/24 at 12:14 PM V9/CNA stated, "(R9) was not a resident on my group the night of 9/19/24, but I was asked to help lay (R9) down. (R9) had been outside at a party, and when he came inside, (R9) was found lopped over the side of his wheelchair in the television room. (V15/RN) called (V8/CNA) and I up to the nurse's desk and asked for us to lay (R9) down. I pushed (R9) to his room with (V8). I asked (V8) how she wanted to transfer (R9) since (R9) seemed weak and was lopped over. (V8) just stated we would transfer (R9) with the stand mechanical lift and get him to his bed. (V8) and I strapped (R9) to the mechanical stand lift machine and started lifting (V8) up in the air. As (V8) and I were lifting him up, (R9) started slipping and was barely hanging on to the (stand lift machine.) (V8) and I attempted to hurry and put (R9) in bed before (R9) fell just to notice the bed was too high. (V8) and I tried to use the controller to lower the bed and the controller wasn't working. (V8) and I attempted to turn (R9) back around to get (R9) in his wheelchair, but (R9) kept getting lower and lower and then let go of the (hand bars of the mechanical stand lift) machine. When (R9) let go of the (stand lift machine) (R9) fell quickly to the ground. If (R9) was on my group that night, I would have not transferred him to the bed when he was visibly weak. I would have gone and

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S9999	Continued From page 6	S9999		

notified (R9's) nurse to have (R9) assessed. I should have done that anyway, but I felt like that was (V8's) responsibility." V9 verified she should have notified R9's nurse prior to transferring R9 when R9 was lethargic and should have ensured the bed was working and in the proper position prior to transferring R9 to the bed.

On 10/7/2024 at 12:30 PM V6/Maintenance Assistant stated, "I get work orders for no electricity all the time for rooms. The staff will move the resident's beds and hit the plug, which breaks a prong off in the outlet. When the staff went to plug the bed back in, the plug-in hits the prong and blows the circuit breaker. I received the work order for (R9) not having electricity in his room on 9/20/24. The staff laid it on my desk on 9/19/24, but I don't usually get to work orders in the same day, it's always the next day I am at the facility. No staff member got ahold of me to let me know (R9) did not have electricity in his room on 9/19/24."

On 10/7/24 at 12:47 PM V7/CNA stated, "I filled out a work order on 9/19/24 around 2:30 PM regarding (R9) not having electricity in his room. (R9's) television was not working. I put the work order on (V6/Maintenance Assistance) desk. I did not tell anyone else or try to get ahold of (V6) to fix it right then."

On 10/8/24 at 1PM V2/Director of Nursing stated, "If any staff notices a change in condition with a resident, they should immediately notify the nurse prior to transferring especially if the resident seems weaker. Also, the staff should have everything positioned correctly prior to transferring any resident." V2 verified no nursing assessment had been performed prior to V8/CNA and V9/CNA transferring R9 from his wheelchair.

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S9999	Continued From page 7 On 10/8/24 at 1:09 PM V3/Assistant Director of Nursing stated "Staff should go to the nurse or myself prior to transferring a resident if they notice a change in the resident's condition or if they notice the resident is weaker. They should never transfer someone to a bed with the bed in high position, they should always ensure the bed is at appropriate position prior to transferring." (B)	S9999		