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 _____	C 04/01/2025

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 Complaint Investigations 2522107/IL187879	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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	S9999		

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resident to meet the total nursing and personal 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 inimun, the followng 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 regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure resident safety after a transfer and failed to keep a resident free from injury for one of three residents (R1) reviewed for accidents/injuries in a sample of four. This failure resulted in R1 sustaining pain, bruising and a hospital visit with fractures to the left ankle and foot.

Findings include:

The facility's undated Residents' Rights for People in Long-Term Care Facilities documents "Your rights to safety: The facility must provide services to keep your physical and mental health, at their highest practical levels."

The facility's Resident Accident/Incident Policy, revised 5/12/15, documents "It is the Policy of

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(named facility) to provide a safe environment for all residents. We understand there will be a time when our best efforts will not be enough. Accidents will happen. Residents will fall."

The facility's Fall Policy and Procedure, revised 1/2/19, documents "It is the Policy of (named facility) to provide an environment conducive to reducing risk for falls. (Named facility) provides interventions to reduce risk factors for falling but cannot guarantee or maintain a fall-free environment."

R1's current clinical record documents R1 is alert and oriented times three (person, place, and time), dependent on staff for all ADLs (Activities of Daily Living) except eating, utilizes a wheelchair, and has diagnoses including but not limited to Dementia with agitation, Peripheral Vertigo, Alzheimer's Disease, Hypertension, Congestive Heart Failure, Anxiety, and Muscle weakness (generalized).

R1's Accident/Incident Report, dated, 2/28/25 at 6:15pm, documents R1 had an unobserved fall from a (reclining) wheelchair while in her room.

R1's Progress note, dated 2/28/25, documents "CNA (Certified Nursing Assistant/V8) notified staff that he went to get bed linens and when (V8) came back to room (R1) was on the floor lying on her side."

On 3/26/25, at 1:14pm, R1 was resting in a (reclining) chair in her room.

On 3/27/25, at 11:06am, V8 CNA stated "I took (R1) to her room then went to the linen closet to put her to bed. When I came back, she had fallen out of the (reclining wheelchair). All four wheels

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were in the air. She was against the mattress which was leaning on the wall. R1's butt (buttocks) was on the foot pedal and rest of her body was up against the mattress against the wall. The chair fell forward." "(R1's) (reclining chair) was in the upright position. I think if I would have reclined it (the chair), I could have prevented it (R1's fall)."

R1's current Care plan documents R1 is totally dependent on staff for transferring and is at risk for falls related to decline in health. This Care plan includes an intervention dated 2/12/25 for nursing staff to ensure R1's (reclining)wheelchair is reclined when sitting in (reclining) wheelchair and not eating.

R1's Skin Tear/Bruise of Unknown Origin Investigation, dated 3/7/25 at 4:15pm, documents R1's left lower leg foot/ankle swollen and bruised. List of resident equipment in use: wheelchair/ (reclining) wheelchair/mechanical lift. Internal Risk Factors identified as "Mobility deficit or immobility, History of fall and partial falls, and restless behavior."

R1's Unusual Occurrence Report Form, dated 3/7/25, documents R1 with complaints of pain to the bridge of her left foot.

The bedside X-ray Results for R1, dated 3/7/25, documents there is an oblique fracture of the distal third of the fibula. "Impression: Non articular fracture of the distal fibula."

R1's Progress note, dated 3/8/25, documents "Resident showing signs of excruciating pain and discomfort." "Per Nursing judgement, this nurse made an educated decision to send resident out to ER (Emergency Room) to be further evaluated.

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Resident agrees with treatment plan stating her 'foot hurts really bad.'"

The local hospital radiology report of R1's left ankle x-ray, dated 3/8/25, documents: "History: Left ankle pain after falling out of chair." "Impression: 1. Acute nondisplaced fracture of the distal fibula. 2. Acute displaced fracture of the fourth metatarsal neck. 3. Acute nondisplaced fractures of the base of the second and third metatarsals."

R1's Hospital After Visit Summary, dated 3/8/25, documents "Reason for Visit: Fall; Ankle Injury."

The facility's Final Report to the State Agency for R1, dated 3/14/25, documents resident (R1) subsequently went out to hospital on 3/8/25 related to increased swelling observed by RN (Registered Nurse). Imaging showed the distal fibula fracture as well as several metatarsals. Resident (R1) returned to the facility with lower extremity in protective wrap. An appointment is scheduled with (Orthopedics) on the 17th of this month. An extensive investigation was complete per the Administrator with staff interviews and review of the cameras.

On 3/27/25, at 2:10pm, R1 was transferred into bed via mechanical lift. Staff removed the splint/boot from her left foot/ankle. R1 was now lying in bed with a bandage noted to her left foot/ankle. At this time R1 stated the following: "It happened when I was in a chair. I turned my head because I heard someone, I thought I knew. When I turned back, I fell to the right and out of my chair. My left foot hit the wall. It hurt. Four staff got me back up. It was a few days later that they sent me out to the hospital and found out it was fractured."

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S9999	Continued From page 5 On 3/28/25, at 1:50pm, V15 R1's Family Member stated "When I asked (R1) how she hurt her foot she told me the same thing. She had said that she was in a chair, heard people talking to her, turned to look towards them and fell out of the chair." R1's Progress note, dated 3/10/25 and signed by V19 Nurse Practitioner/NP, documents "INTERVAL HISTORY: Pt (patient) is up in her WC (wheelchair). She has some pain to her LLE (left lower extremity). Was noted to be sore, bruised and swollen. Did have an XR (x-ray) that showed: Closed left ankle fracture and multiple closed fractures on metatarsal bone of left foot. Splint in place and referred to podiatry." On 4/1/25, at 11:28am, V19 Nurse Practitioner/NP confirmed that (R1's) fracture is most likely from a previous fall. On 4/1/25, at 1:34pm, V2 Director of Nursing/DON stated, "I was notified about (R1's) foot when (V15 R1's Family Member) came in and asked about it on Friday March 7th." "I went to (R1's) room. I saw edema, significant bruising to ankle, top of foot and posterior aspect of foot/ankle." On 3/28/25, at 2:50pm, V1 Administrator confirmed that R1 did have a fall on 2/28/25 and confirmed R1's fractures to her ankle/foot. As of 3/28/25, R1's medical record did not document any further falls/accidents/incidents between R1's fall on 2/28/25 and 3/7/25. (B)	S9999		