

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Sharon Health Care Elms		STREET ADDRESS, CITY, STATE, ZIP CODE 3611 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 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** 32061 Based on observation, interview, and record review, the facility failed to transfer a resident with the required mechanical lift, for one of three residents (R1) reviewed for falls in a sample of 3. This failure resulted in R1 falling twice and during the second fall sustaining a periprosthetic distal left femur fracture, ongoing pain, and psychosocial fear of being transferred with a mechanical lift. FINDINGS INCLUDE: The facility policy, Fall Policy and Procedure directs staff, 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 falling .Should the resident be observed sitting on the floor or being assisted by staff to sit down on the floor, the nurse will be notified and a fall report will be completed R1's current facility Face Sheet documents that R1 was admitted to the facility on [DATE] after a fall with a Left Hip Fracture. This same form includes the following diagnoses: Cerebral Palsy, Blindness of One Eye, History of Cerebral Infarction, Paraplegia, Depression with Psychotic Features and Anxiety. R1's (current) Care Plan, dated 6/16/2023 includes the following Focus Areas: (R1) is at risk for falls related to history of cerebral palsy, left hip fracture and left-sided paraplegia. Also included are the following Interventions: Transfers: (R1) requires extensive assistance by two staff to move between surfaces using a (mechanical) lift. R1's Minimum Data Set Assessment, dated 11/14/2024 documents, ADL's (Activities of Daily Living): Impairment on one side of lower extremity; requires use of wheel chair; requires substantial/max (maximum) assistance for bathing, dressing, and bed mobility and is dependent for all transfers. Requires extensive assistance of 2 staff members and (mechanical) lift for all transfers. R1's Fall Risk Evaluation, dated 11/24/2024 documents, One to two falls past 3 months, Intermittent confusion, Chairbound/Incontinent, 1-2 Predisposing Diseases, Gait/Balance- not able to perform function and Takes 1-2 (High Risk) Medications. Risk For Falls: (R1) is at risk for falls. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 146098	Facility ID: 146098 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Sharon Health Care Elms		STREET ADDRESS, CITY, STATE, ZIP CODE 3611 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 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Nursing Progress Notes, dated 1/9/2025 at 3:51 P.M. document, CNA (Certified Nursing Assistant) was behind (R1) holding (R1) at the shower bar while attempting to transfer from (R1's) w/c (wheelchair) to the shower chair, for a shower. (R1) thought her phone had fell out of her belongings onto the floor and turned around suddenly and fell on her buttocks. No apparent injury. The facility Fall Investigation form, dated 1/9/2025 documents,(V5/Certified Nursing Assistant) was behind (R1) holding her while (R1) held shower bar. (R1) jerked around and fell on her buttocks. Recommendations/Interventions: Staff Member (V5/Certified Nursing Assistant) was educated on (correct) transfer for (R1) and the use of a shower bed. R1's Nursing Progress Notes, dated 1/24/2025 at 3:48 P.M. document, This Nurse (V4/Registered Nurse) had a conversation with (V6/Certified Nursing Assistant) (who) stated (R1) only told me her leg hurt and that (R1) didn't didn't know why. (V6/Certified Nursing Assistant) stated I transferred (R1) and (R1) started shaking and buckled and I lowered (R1) to the floor. There was no fall, I lowered (R1) to the floor. R1's Nursing Progress Notes, dated 1/24/2025 at 4:00 P.M. document, Certified Nursing Assistant came to Nurses' Desk and (stated) (R1) needed something for pain. (Nurse) went to (R1's) room and asked (R1) what was wrong and what hurt. (R1) stated her L (left) upper thigh hurt. (I) asked (R1) what type of pain, aching, sharp and (R1) replied deep aching. (Nurse) gave (R1) (Acetaminophen) (Analgesic) at (3:50 P.M.). R1's Nursing Progress Notes, dated 1/24/2025 at 6:41 (P.M.) document, Upon coming on shift, (V4/Registered Nurse) reported that (V6/Certified Nursing Assistant/CNA) had lowered (R1) to the floor. CNA indicated that (R1) is complaining of pain in the left leg, describing it as excruciating. (R1) also stated that she is unable to move her left leg. Upon assessment, the nurse observed swelling to (R1's) right ankle. The physician has been notified of the situation. R1's Nursing Progress Notes, dated 1/24/2025 at 6:56 P.M. document, MD (Medical Doctor) states send (R1) to the ER (emergency room). (R1) to be further evaluated. The facility Fall Investigation form, dated 1/24/2025 documents, (R1) stated her left thigh hurt and she didn't know why and (R1) had pain when nurse tried to lift her leg. Later, (V6/CNA) stated she transferred (R1) and (R1) began shaking and buckled and (V6) lowered (R1) to the floor. Recommendations/Interventions: (V6) was disciplined and all the other staff will be inserviced to use (mechanical) lift only with (R1). R1's (hospital) History and Physical documents, admitted : 1/25/25. (R1) with past medical history for depression with anxiety, seizure disorder, and left-sided hemiplegia due to cerebral palsy who presented to the hospital after a fall at (facility). (R1) was reportedly being transferred by the staff when (R1) was dropped, landing on her left side. Imaging in the ED (Emergency Department) showed questionable left hip injury as well as a distal periprosthetic femur fracture on the left. (R1) reports significant discomfort in her left leg at this time, more in the distal thigh but has some pain in the hip. ASSESSMENT AND PLAN: Closed fracture of distal end of femur. Orthopedic surgery has been consulted. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Sharon Health Care Elms		STREET ADDRESS, CITY, STATE, ZIP CODE 3611 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 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/10/2025 at 10:45 A.M., R1 was seated in a wheel chair in the (facility) Dining/Activity Room with other residents, at a table for coffee and donuts. (R1) recalls falling two times, once when staff dropped me. R1 becomes visibly upset, crying when talking of incident. Repeats over and over, I hurt. I'm afraid of the lift. Refused to answer further questions surrounding incidents. On 2/10/2025 at 10:59 A.M., V4/Registered Nurse (RN) stated, I have been a nurse here for the past ten years and three weeks. (R1) had a history of a previous fall with a fracture, left-sided paraplegia, and a history of cerebral palsy. (R1) was supposed to be a two person, lift for all transfers. V6/Certified Nursing Assistant (CNA) came to me and asked if (R1) had anything for pain. (V6/CNA) said (R1's) leg hurt. I went to see (R1) and she told me that (V6/CNA) had dropped her and hurt her leg. When I questioned (V6/CNA), she told me she was transferring (R1) by herself from the bed to (R1's) wheelchair and (R1's) leg buckled and (V6/CNA) lowered (R1) to the floor. (V6/CNA) kept repeating that she only lowered (R1) to the floor. I didn't do a fall report right away, call the doctor, or R1's family or the DON (V2/Director of Nurses). I didn't consider it a fall. It wasn't until later that (V2/DON) told all of us that even when you lower someone to the floor, it's considered a fall. (R1) has always been a (mechanical) lift for all transfers. (V6/CNA) should not have been trying to transfer (R1) by herself. On 2/10/2025 at 12:25 P.M., V3/Care Plan Coordinator stated she was responsible for all the facility fall investigations. States (R1) is at risk for falls due to history of CP (Cerebral Palsy), paraplegia and blindness to (the) left side and history of falls with a fracture. States (R1) does not stand and has been a (mechanical) lift for the past two years. States facility policy is for all mechanical lift transfers to be performed with two staff members present. States (R1's) care plan addressed (R1's) interventions including the use of a mechanical lift for all transfers. States (R1's) facility care cards, addressed (R1's) need for a mechanical lift for all transfers. States care cards are used to inform the CNAs (Certified Nursing Assistants) what specific care each resident requires. States she investigated both of (R1's) falls in January. States on 1/9/25 at 3:00 PM, (V5/CNA) was attempting to transfer (R1) by herself, without using a mechanical lift, from (R1's) wheel chair to a shower chair. Confirmed that (R1) fell on her buttocks. States (V5/CNA) was educated on the need to use a mechanical lift to transfer (R1) from her wheelchair onto the facility shower bed, for (R1) to receive a shower. Also confirms that (R1) fell again on 1/24/25 at 3:40 PM when (V6/CNA) transferred (R1) by herself, without the use of a mechanical lift from (R1's) bed to (R1's) wheelchair, when (R1's) leg gave out and she lowered (R1) to the floor. States (V6/CNA) was disciplined for failure to use a mechanical lift and another staff assistance for all of (R1's) transfers and all other nursing staff were educated on the need to use a mechanical lift to transfer (R1). On 2/10/2025 at 1:12 P.M., V5/Certified Nursing Assistant (CNA) confirmed on 1/9/25 she attempted to transfer (R1) from the wheelchair to a shower chair, while in the shower room. (V5/CNA) states (R1) thought she had dropped her phone and turned around suddenly to look for it and fell on to (R1's) buttocks. (V5/CNA) states she didn't know she was supposed to transfer (R1) at all times with a mechanical lift, states she hadn't worked with (R1) very often. On 2/10/2025 at 1:18 P.M., V6/Certified Nursing Assistant verified on 1/24/25 she attempted to transfer (R1) from the bed into (R1's) wheelchair, when (R1's) leg gave out and she lowered (R1) to the floor. (V6/CNA) states she wasn't aware she was supposed to transfer (R1) with a mechanical lift and additional staff assistance, at all times. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Sharon Health Care Elms		STREET ADDRESS, CITY, STATE, ZIP CODE 3611 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 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/10/2025 at 1:26 P.M., V7 and V8/Certified Nursing Assistants prepared to transfer (R1) from the wheelchair to bed for incontinence care via a mechanical lift. (R1) began yelling out and was tearful with any movement of her left leg.		