

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

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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 04/01/2025
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33973 Based on observation, interview and record review, the facility failed to perform hand hygiene and glove changes during pressure ulcer treatments. The facility also failed to ensure pressure ulcer treatments were completed as ordered. These failures effect three of three residents (R2, R3, R4) reviewed for pressure ulcers in a sample of four. Findings include: The facility's undated Wound Care policy documents Purpose: To provide guidelines for the care of wounds and soiled dressings to decrease the potential for nosocomial infections. Steps in the Procedure: 1. Wash your hands thoroughly before beginning the procedure. 11. Put on exam glove. Loosen tape and remove dressing. 12. Pull glove over dressing and discard into appropriate receptacle. Wash hands. 13. Put on disposable gloves. 14. Use no-touch technique. Use tongue blades and applicators to remove ointments and creams from their containers. 15. Pour liquid solutions directly on gauze sponges. 17. Cleanse wound with solution. 20. Dress wound. [NAME] tape with initials, time, and date and apply to dressing. 21. Pick up soiled items. Discard into designated container. Remove gloves and discard into trash bag/container. Wash hands. The facility's undated Using Gloves policy documents Purpose: To provide guidelines for the use of gloves. Objectives: 1. To prevent the spread of infection and disease to residents and employees; 2. To protect wounds from contamination. Miscellaneous: 1. When gloves are indicated, disposable single-use gloves should be worn .4. Nonsterile gloves should be used primarily to prevent the contamination of the employees' hands when providing treatment or services to the resident and when cleaning contaminated surfaces. 5. Wash hands after removing gloves. Gloves do not replace handwashing. The facility's undated Handwashing policy documents When to Wash Hands: 6. After handling used dressings, specimen containers, contaminated tissues, linen, etc. 8. After handling items or work surfaces potentially contaminated with a resident's blood, excretions, or secretions. 12. Upon completion of duty. The facility's undated Treatment of Pressure Ulcers (Bedsore) policy documents Purpose: The purpose of this procedure is to provide guidelines for the treatment of pressure ulcers to facilitate healing. This policy includes to 19. Dress the pressure sore with the prescribed dressing. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Physician's Order Policy documents Purpose: The purpose of this policy is to establish guidelines for the ordering, processing, and management of physician orders in a long-term care facility, ensuring compliance with State and Federal regulations, and promoting the health and safety of residents. Procedures: 3. Order Implementation - All medications and treatments shall be administered as per the orders, with documentation in the resident's medical record. 1. R2's Wound Evaluation and Management Summary, dated 3/19/25, documents R2 has a Stage II p/u (pressure ulcer) to right buttock measuring 7 x (by) 4 x 0.1cm/centimeters; Stage III left buttock measuring 2 x 1 x 0.1cm; and Stage III p/u to coccyx measuring 2 x 1 x 0.2cm. R2's current Physician Order Sheet/POS documents Right Buttocks, Left Buttocks and Coccyx - cleanse with normal saline solution, apply hydrocolloid 3 times per week, Monday, Wednesday, Friday on Day Shift every day. R2's current Physician Order Sheet/POS documents an order for Right Buttocks - cleanse with Normal saline solution and apply hydrocolloid three times per week, on Day Shift every Monday, Wednesday, Friday; Start Date: 2/28/25. D/C (Discontinue Date): 3/20/25. R2's March 2025 Treatment Administration Record/TAR documents this treatment was not completed on Friday 3/7/25. On 3/26/25, at 11:04am, R2 is sitting in a wheelchair in her room. V4 Registered Nurse/RN/Wound nurse prepared supplies of Normal Saline/NS and a hydrocolloid dressing to perform wound care on R2's coccyx. V4 donned gloves and gown. R2 stood up while V4 removed R2's dressing soiled with light serosanguinous drainage. R2's buttocks and coccyx had pink open areas with exposed dermis and granulation noted. With the same soiled gloves V4 RN cleansed the wound with saline soaked gauze and applied the hydrocolloid dressing. V4 removed gown/gloves, left R2's room, then used hand sanitizer out in hall and walked into R3's room to perform wound care. V4 did not perform hand washing. On 4/1/25, at 1:34pm, V2 Director of Nursing/DON stated There was a concern brought to (V4 Wound Nurse) after a weekend about a wound not being dressed. This was for (R2). I discussed with the nurses about orders and supplies and that we had both. Not sure what happened. One of the nurses, an agency nurse (V22 RN) indicated she didn't know what the treatment was. It is inappropriate to miss a treatment. They are in the residents' records. 2. R3's Wound Evaluation and Management Summary, dated 3/26/25, documents R3 has a Stage IV pressure wound of the right lateral foot (1.8 x 1.5 x not measurable cm/centimeters) and a Diabetic wound of the right distal first toe (2.5 x 3.5 x not measurable cm). R3's current POS documents Right Lateral Foot and Right Foot First Digit - cleanse areas with Normal saline solution and apply calcium alginate with silver cover with bordered gauze on Day Shift every day. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/25, at 11:15am, R3 is lying in bed. V4 RN/wound nurse prepared supplies of Normal Saline/NS, Calcium alginate with silver and bordered gauze to change the dressing on R3's right lateral foot. V5 RN assisted. V4 donned gloves and gown. With gloved hands V5 RN removed the outer bordered gauze. V4 RN removed the calcium with silver dressing which was soiled with moderate serosanguinous drainage. R3 had an open area with necrotic tissue to his right lateral foot. With the same soiled gloves V4 cleansed the wound with saline soaked gauze, applied the Calcium with silver dressing, then applied an outer bordered gauze dressing. V4 RN changed gloves without any hand sanitizing then performed the same physician ordered treatment in the same manner to R3's diabetic wound of the right first toe. V4 RN removed gown/gloves, left R3's room, then used hand sanitizer out in hall and walked into R4's room to perform wound care. V4 did not perform hand washing. 3. R4's Wound Evaluation and Management Summary, dated 3/26/25, documents R4 has a non-pressure wound of the left anterior knee; etiology trauma/injury (1.8 x 1.5 x not measurable cm/centimeters) and Stage IV pressure wound of the left lateral ankle (1.5 x 1.5 x not measurable cm). R4's current Physician Order Sheet/POS documents Left Ankle and Left Knee - cleanse area with Normal saline solution and apply hydrocolloid every three days on Day Shift. On 3/26/25, at 11:25am, R4 was lying supine in bed. V4 RN gathered supplies of Normal Saline and a hydrocolloid dressing to perform wound care on R4's left ankle and knee. V4 donned gloves and a gown then removed R4's dressing from his left knee that was soiled with moderate serosanguinous drainage. V4 stated it is abscess drainage. With the same soiled gloves, V4 RN cleansed the open wound with saline soaked gauze and applied the hydrocolloid dressing to R4's left knee. V4 removed her gloves then donned a new pair of gloves without sanitizing in between glove change. V4 RN removed the dressing from R4's left ankle which was soiled with light serosanguinous drainage. With the same soiled gloves, V4 cleansed the open wound with saline soaked gauze and placed a hydrocolloid dressing over it. V4 RN removed her gloves, left R4's room and used hand sanitizer out in the hallway. V4 RN did not perform hand washing. On 3/26/25, at 11:35am, V4 RN/Wound nurse stated that she does not use hand sanitizer in between glove changes if her hands are clean. V4 stated that she should have changed her gloves after the dirty task and before going to clean. V4 confirmed V4 should have also changed gloves after cleansing the wound. V4 stated Normally I wash my hands, use hand sanitizer before and after then wash my hands after that since my hands get sticky and break out from the hand sanitizer. I did not do that. I was trying to hurry for you. On 4/1/25, at 1:34pm, V2 Director of Nursing/DON stated that during wound treatments nurses are to change gloves after removing old dressing, put new gloves on, cleanse the wound then put new gloves on before putting new dressing on. Should use hand sanitizer between glove changes and wash hands in between residents.		

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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. 33973 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 (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 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). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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.		