

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>146098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SHARON HEALTH CARE ELMS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3611 NORTH ROCHELLE</b> <b>PEORIA, IL 61604</b>		
(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	F 000			
F 323 SS=G	<p>Original investigation of complaint 1425169/IL73232.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed prevent one of three sampled residents (R2) from falling out of bed while providing incontinent cares. R2 sustained a left distal impacted femur fracture.</p> <p>Findings include:</p> <p>R2's current Minimum Data Set (MDS) dated 10/12/14 notes R2's bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) as needing extensive assistance of two staff. MDS notes R2's weight is 311 pounds.</p> <p>Facility Accident/Incident Report for R2 dated 11/9/14 reads, "Resident (R2) fell out of low air mattress bed onto floor yelling and complaining of left leg pain. Left side hemiplegia from CVA. States she was grabbing for table. Lifted off floor</p>	F 323			11/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 323	<p>Continued From page 1</p> <p>by (Mechanical Lift) and put back to bed. Left leg having more pain and externally rotated."</p> <p>Local Hospital Emergency Department report dated 11/9/14 noted R2 to be oriented to person, place and time. Report reads, "Pt (R2) reports that she fell out of bed this morning while her Aide (E5 Certified Nurse's Aide) was cleaning her up and pushed her a little too hard to one side. Fell out of bed onto her left side. Having left hip pain now. Felt like her knee went pop."</p> <p>Emergency report note dated 11/9/14 at 5:07 P.M. reads, "Left Knee xray reviewed showing left distal impacted femur fracture."</p> <p>On 11/18/14 at 1:58 P.M. E5 stated that while performing incontinent care on R2, E5 rolled R2 away from E5 onto R2's right side. E5 said, "I was not paying attention to (R2's) feet while I turned her and that's when she rolled out of bed."</p>	F 323			