STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	C 11/19/2014

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

(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 Original investigation of complaint 1425169/IL73232.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. 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. Findings include: 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. 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	F 323		11/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146098	A. BUILDING _____ B. WING _____	C 11/19/2014

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

(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 323	Continued From page 1 by (Mechanical Lift) and put back to bed. Left leg having more pain and externally rotated." 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." Emergency report note dated 11/9/14 at 5:07 P.M. reads, "Left Knee xray reviewed showing left distal impacted femur fracture." 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."	F 323		